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Authorization for Disclosure of Information

* indicates a required field

*** I hereby authorize and direct (enter name of clinician):**

_____

*** To:**

_____DISCLOSE the following information:

_____EXCHANGE the following information:

*** To / With:**

_____

_____

For the following purpose(s):

_____

*** This authorization expires on this date_____ or in 90 days, whichever date is sooner.**

By signing this authorization form: I understand that my records contain information regarding my mental health. I give specific permission for this information to be released. I understand that my records are protected under State and Federal law and cannot be disclosed without my written consent unless otherwise provided for by law.

*** Signature**:_____**Date**:_____