AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

NAME OF
PATIENT:_____

DATE OF BIRTH:_____ PHONE#_____

I Authorize: To Release To:

_____ _____

_____ _____

_____ _____

___ Check if you would prefer verbal discussion only—do not release written records

I authorize the use and disclosure of my individually identifiable mental health and medical information, including verbal and written exchanges about the information unless I indicate otherwise. I understand that this authorization is voluntary and may be revoked at any time. I understand that this authorization will expire on _____ or, if not date or event is specified, 12 months from the date of signing.

A copy of this authorization will be treated in the same manner as the original.

_____

Signature of Patient

_____

Date