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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client's Name: ____________________________ Date of Birth: _________________________

Parent's Name (if applicable): ____

I request and authorize ____ to release healthcare information of the client named above to:

Name: ____

Organization: ____

Phone: ____________________________ Email: _____________________________

This request and authorization applies to releasing mental health records regarding:

□ Information relating to the following treatment, condition, or dates:________________

□ All information

□ Specific Information Only: ____

Client Signature: ____________________________ Date Signed: ______________________

Parent Signature: ___________________________ Witness: _________________________

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED