AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

PATIENT NAME: _____ Date of Birth: _____

Address (Mailing):_____Phone: _____

I authorize _____ of Envision Counseling to use or disclose information from my mental health record, which may include information about psychiatric diagnosis and treatment and substance abuse issues to:

Name: _____Phone:_____

Address:_____ FAX: _____

_____

Dates of Treatment: _____

Purpose of Disclosure: _____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Envision Counseling at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
5. My health care and payment for my health care at Envision Counseling will not be affected if I do not sign this form.
6. I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand the Authorization.

_____ or _____

Signature of Patient Date Parent/Legal Guardian Date

Relationship to Patient_____