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Request For Authorization for Release of Information

By signing this document, I, (name of patient) _____ (hereinafter "Patient") herby authorize (name of provider) _____ (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of Provider's treatment of Patient, including, but not limited to, Provider's diagnosis of Patient, to (name and functions of the person or entity to whom disclosure is made)
_____
_____
_____ .

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at (insert provider's address) _____ to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:
_____
_____
_____.

The specific uses and limitations on the types of medical information to be discussed are as follows: ____
_____
_____
_____.

Such disclosure shall be limited to the following specific types of information:
_____
_____
_____.

Provider shall not condition treatment upon Patient signing this authorization.

Patient has the right to refuse to sign this from.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule, although such information may be protected by applicable California law.

This authorization shall remain valid until: _____

_____ _____
Patient Date