PSYCHSTRATEGIES

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL MENTAL HEALTH INFORMATION

I hereby authorize PsychStrategies and PsychStrategies' providers to disclose mental health treatment information:

Type of Disclosure: € Copies of Records € Verbal Exchange

I understand that the record may contain protected information and I consent to the release of:
___Psychotherapy Notes ___Medication Evaluations ___Drug/Alcohol Information

___Evaluations/Assessments ___ Psychological Information ___HIV Results ___Other

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Disclose To:

Patient Name:_____ Name:_____

Date of Birth:_____ Address:_____

Address:_____ _____

Phone:_____ Phone_____Fax:_____

The disclosure of information is requested for the following purpose:_____

I understand that:

- I have a right to receive a copy of this authorization.
- Any cancellation or modification of this authorization must be in writing and received by PsychStrategies to be effective.
- I have the right to revoke this authorization at any time unless PsychStrategies has taken action upon it.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected.
- I have a right to refuse to sign this authorization.
- Treatment at PsychStrategies will not be dependent on providing or refusing to provide this authorization.

This Authorization will remain in effect for 1 year unless otherwise stipulated below:

Effective:_____Expiration:_____

Signature:_____Date:_____
(Client/ Legal guardian/Legally authorized representative of client)

Person completing form if other than patient:_____

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