LETTER OF AUTHORIZATION FOR RELEASE OF PSYCHIATRIC RECORDS

Patient Information:
Full Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number (Optional): [XXX-XX-XXXX]
Phone Number: [Your Phone Number]

To:
Facility/Provider Name: [Name of Facility holding records]
Address: [Street Address]
City, State, Zip: [City, State, Zip Code]

I hereby authorize the release of my psychiatric and mental health records to:
Recipient Name: [Name of Person or Organization]
Address: [Street Address]
City, State, Zip: [City, State, Zip Code]
Fax/Email (if applicable): [Fax Number or Email]

Information to be Released:
[ ] All psychiatric and mental health records (including intake, diagnosis, and treatment notes)
[ ] Specific dates of service: From [Date] to [Date]
[ ] Evaluation and testing results only
[ ] Medication history only

Purpose of Disclosure:
[ ] Legal purposes
[ ] Continuity of care / Referral
[ ] Personal use
[ ] Insurance claim

Expiration and Revocation:
This authorization will expire on [Date] or upon the following event: [Event]. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

Sensitive Information Notice:
I specifically authorize the release of information pertaining to psychiatric/mental health treatment. I understand that these records are protected under federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Signature:

____
(Signature of Patient or Legal Representative)

Date: ______________________________________

Relationship to Patient (if signed by Legal Representative): ___________________