

Authorization for Disclosure of Confidential Psychiatric Records

Patient Name: [Full Name]

Date of Birth: [MM/DD/YYYY]

Patient Address: [Street Address, City, State, Zip Code]

Patient Phone: [Phone Number]

1. Authorization to Release Information

I hereby authorize [Name of Mental Health Provider/Clinic] to release the psychiatric and mental health records of the patient named above to:

Recipient Name/Organization: [Name of Recipient]

Recipient Address: [Full Address]

Recipient Fax/Email: [Fax Number or Email Address]

2. Information to be Disclosed

I request the following information to be released (check all that apply):

- Complete Psychiatric Record
- Diagnosis and Treatment Plan
- Medication History
- Progress Notes
- Psychological Testing Results
- Discharge Summary
- Other: [Specific Description]

3. Purpose of Disclosure

The purpose of this disclosure is for:

- Continued Medical Care
- Legal Representation
- Insurance Claim/Evaluation
- Personal Use

- Other: [Specific Purpose]

4. 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 it.

5. Acknowledgment of Sensitivity

I understand that my records may contain sensitive information regarding my mental health, psychiatric treatment, and/or drug and alcohol abuse history. I specifically authorize the release of such information.

6. Signature

Patient/Legal Representative Signature

Date

Relationship to Patient (if signed by Representative)