

Mental Health Record Release Consent Form

Please complete all sections of this form to authorize the release of mental health records. This form is designed to be filled out and printed.

1. Patient Information

Patient Full Name:

Date of Birth:

Phone Number:

Address:

2. Authorizing Entity (Disclosing Party)

I hereby authorize the following individual or organization to release my mental health records:

Name of Provider or Facility:

Address:

Phone Number:

3. Receiving Entity (Recipient)

Please send my mental health records to the following individual or organization:

Name of Recipient or Facility:

Address:

Phone Number:

4. Information to be Disclosed

Specify the exact mental health records you authorize to be released (e.g., Progress Notes, Intake Assessment, Treatment Plans, Psychological Evaluation, or write "All Records"):

5. Purpose of Disclosure

State the purpose for releasing this information (e.g., Continued Care, Legal, Personal Use, Insurance):

6. Expiration and Revocation

This authorization will automatically expire on the date or event specified below. If no date is specified, this authorization will expire one year from the date of signature.

Expiration Date or Event:

MM/DD/YYYY or Event Description

7. Signature and Authorization

By signing below, I understand that I am authorizing the release of sensitive mental health information. I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in reliance on it.

Patient or Legal Representative Signature:

Sign here after printing

Date Signed:

MM/DD/YYYY

If Legal Representative, state relationship to patient: