Mental Health Medical Authorization Release Form

Patient Information

Name

Date of Birth

Phone Number

Address

Insurance ID Number

Recipient of Information

Name of Person or Organization

Address/Fax/Email

Provider/Facility Information

Name of Provider/Facility

Address

Phone

Information to be Released

☐ Assessment/Evaluation

☐ Treatment Records

☐

Diagnosis

Progress Notes

Other (specify)

Purpose of Release

Authorization

I authorize the above-named provider/facility to release the specified information to the insurance carrier or related organization for the purpose stated above. I understand that this authorization is voluntary and that I may revoke it at any time in writing.

Effective Date

Date Authorization Expires

Signature of Patient/Authorized Representative

Date

If Representative, Describe Authority