Mental Health Insurance Authorization to Release Records

Patient Information

Full Name

Date of Birth

Address

Phone

Recipient Information

Name/Organization

Address

Phone

Fax

Information to be Released

Purpose of Release

Authorization Terms

☐ I authorize the release of the specified information to the recipient identified above.

☐ I authorize verbal communication regarding my records.

☐ This authorization expires on:

Patient Signature

Date

If patient is a minor or unable to sign, authorized representative:

Relationship

Additional Notes or Restrictions