Patient Consent to Release Mental Health Records

I hereby authorize the release of my mental health records as specified below:

Patient Name

Date of Birth

Phone

Address

Records to be Released

Released From (Provider/Facility Name)

Provider/Facility Address

Released To (Individual/Organization Name)

Recipient Address/Fax/Email

Purpose of Release

I understand that this authorization is voluntary and I may revoke it at any time by notifying the provider in writing. This authorization will expire one year from the date signed unless otherwise indicated here:

Patient Signature

Date

Legal Guardian/Representative (if applicable)