## **Mental Health Information Release Form**

## **Patient Information**

Full Name
Date of Birth
Address
Address
Phone Number
Desirient of Information
Recipient of Information
Name / Organization
Address
Phone Number
r none number
Information to be Released
Type of Information
Purpose of Release

I authorize the release of my mental health information as specified above.
This authorization will expire on
Signature of Patient
Date
Signature of Witness
Date