Mental Health Records Release Form

Patient Information

Full Name

Date of Birth

Address

Phone Number

Records to be Released

Release records to (Name/Organization):

Address

Phone Number

Fax/Email

Information to be released:

Reason for release:

Authorization

☐ I authorize the release of my mental health records as described above.

☐ This authorization will expire on:

If no date is specified, this authorization will expire 12 months from signature.

Signature

Date

I understand that I may revoke this authorization at any time by providing written notice.