Authorization of Release for Mental Health Information

Client Information

Name: ____

I, ___________________________________, request and authorize Modify PC and my

therapist_____________________________________to disclose and release information to the following:

Name_____________________________________ Entity _______________________________

The nature of the information to be disclosed includes:

- ⬜ Any and all clinical and mental health information
- ⬜ Intake/assessment
- ⬜ Dates of treatment
- ⬜ Progress notes
- ⬜ Treatment summary
- ⬜ Other _____________________________

Information is being released for the purpose of:

- ⬜ Treatment coordination/planning/assessment
- ⬜ Legal issues
- ⬜ Other: ____

This authorization expires on ___/___/______.

It has been explained to me that the consequences of my refusal to consent to this authorization will result in the following:
INFORMATION AND RECORDS WILL NOT BE DISCLOSED
I understand that I have a right to inspect and copy the information to be disclosed.
I understand that I may revoke this consent at any time by giving written notice.

____ ________________________
Client's signature (age 12 and older) Date

____ ________________________
Parent/guardian of minor age 11 and younger Date

____ ________________________
Witness signature Date

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