

# PSYCHSTRATEGIES

## AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL MENTAL HEALTH INFORMATION

I hereby authorize PsychStrategies and PsychStrategies' providers to disclose mental health treatment information:

Type of Disclosure:    Copies of Records                       Verbal Exchange

I understand that the record may contain protected information and I consent to the release of:  
\_\_\_ Psychotherapy Notes              \_\_\_ Medication Evaluations              \_\_\_ Drug/Alcohol Information  
\_\_\_ Evaluations/Assessments        \_\_\_ Psychological Information        \_\_\_ HIV Results        \_\_\_ Other

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**Disclose To:**

Patient Name: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Phone \_\_\_\_\_ Fax: \_\_\_\_\_

The disclosure of information is requested for the following purpose: \_\_\_\_\_

**I understand that:**

- I have a right to receive a copy of this authorization.
- Any cancellation or modification of this authorization must be in writing and received by PsychStrategies to be effective.
- I have the right to revoke this authorization at any time unless PsychStrategies has taken action upon it.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected.
- I have a right to refuse to sign this authorization.
- Treatment at PsychStrategies will not be dependent on providing or refusing to provide this authorization.

This Authorization will remain in effect for 1 year unless otherwise stipulated below:

Effective: \_\_\_\_\_ Expiration: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Client/ Legal guardian/Legally authorized representative of client)

Person completing form if other than patient: \_\_\_\_\_

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