# Authorization to Disclose Mental Health Information Form Sample

The **Authorization to Disclose Mental Health Information** form sample provides a standardized template for individuals to grant permission for sharing their mental health records. This form ensures confidentiality while facilitating communication between healthcare providers, insurers, and other authorized parties. Proper use of this authorization helps protect patient privacy and supports coordinated care.

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## Sample Authorization Form

**Patient Information**

Name: _____

Date of Birth: _____

Address: _____

**Recipient of Information**

Name or Organization: _____

Address: _____

**Information to be Disclosed**

- ☐ Diagnosis
- ☐ Treatment Records
- ☐ Medication History
- ☐ Other (please specify): _____

**Purpose of Disclosure**

- ○ Treatment/Continuity of Care
- ○ Insurance
- ○ Personal
- ○ Other (please specify): _____

**Authorization Details**

This authorization will expire on (date or event): _____

☐ I understand that I have the right to revoke this authorization in writing at any time.

☐ I consent to the use of my electronic signature on this form.

**Signature**

Signature: _____

Date: _____

Submit Authorization