Authorization to Release Mental Health Information Form Sample

The **Authorization to Release Mental Health Information Form** sample facilitates the secure sharing of sensitive mental health records between authorized parties. This form ensures compliance with privacy laws while granting consent for the release of confidential information. Proper use of this document supports effective communication and coordinated care in mental health services.

Authorization to Release Mental Health Information

Client Name:

Date of Birth:

Address:

I authorize the following provider/agency to release my mental health information:

Release Information To:

Type of Information to be Released:

- ☐ Mental Health Assessment/Evaluation
- ☐ Treatment Plan/Progress
- ☐ Medication Records
- ☐ Other:

Purpose of Release: Select

Date Range for Information (if applicable):

e.g., Jan 2022 - Dec 2023

This authorization:

- ○ Expires in one year
- ○ Other:

Client's Rights:

- I understand that I may revoke this authorization at any time in writing.
- I understand that refusal to sign this form will not affect my ability to obtain treatment.
- I understand that information released may be subject to re-disclosure by the recipient.

Client Signature:

Date:

Witness Signature (if required):

Submit