Mental Health Records Release Authorization Form Sample

The **mental health records release authorization form sample** is a crucial document that allows individuals to grant permission for the disclosure of their psychological and counseling information. This form ensures confidentiality while enabling authorized parties to access necessary mental health data for treatment, legal, or personal purposes. Proper completion of this authorization safeguards patients' privacy rights and complies with healthcare regulations.

Authorization Form Sample

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Recipient Information

Name/Entity to Release To:

Address:

Phone Number:

Authorization Details

Purpose of Release:

- ☐ Treatment
- ☐ Legal
- ☐ Personal

Description of Information to be Released:

Consent and Signature

I hereby authorize the release of my mental health/psychological records as described above. I understand this authorization is voluntary and can be revoked by me in writing at any time.

Signature:

Date:

Submit Authorization