Authorization for Disclosure of Information

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I hereby authorize and direct:

Entity to authorize: _____

To do the following:

Actions to authorize

- [ ] Disclose the information below
- [ ] Exchange the information below

To/With:

For the following purpose(s):

This authorization expires on the date selected or in 90 days, whichever date is sooner.

By signing this authorization form: I understand that my records contain information regarding my mental health. I give specific permission for this information to be released. I understand that my records are protected under State and Federal law and cannot be disclosed without my written consent unless otherwise provided for by law.

Name: _____ **Date:** _____ dd / mm / yyyy