AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO PROFESSIONALS

Name of client: _____ Date of birth: _____

I understand my records contain information about my therapy sessions and my mental health. I understand all my records are protected by state and federal laws that require they are kept confidential and require my written consent to disclose.

I , _____ (*client's name*), hereby authorize _____ (*practice/therapist name*) to disclose _____ (*name of document*) to _____ (*name of recipient*) for the sole purpose of:

_____.

I understand I have the right to revoke this release at any time. This release will expire on _____ (*date of agreed expiration*) or 90 days from the date this form was signed.

I have been informed and understand this authorization to release records and information, the nature of listed content that I am willing to release, and the implications of their release. This request is voluntary.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of parent/guardian/representative	Printed name and Relationship	Date

I witnessed the person understood the content of this authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of witness	Printed name	Date

❑ Copy for patient or parent/guardian ❑ Copy for professional/clinic ❑ Copy for family member