Authorization for use and disclosure of protected information

What's this for?
To allow the Mood Treatment Center to send records or communicate with other people.

❶ Patient information

Name: _____ DOB: _____

❷ Who you're allowing communication with, and what you want released

I (the above named patient) request the Mood Treatment Center communicate with:

Person, provider or facility: _____

City: _____ State: _____

To release the following information:

___ Psychiatric Records
___ Substance Abuse Treatment
___ Psychological Testing
___ Records of Psychiatric Hospitalization
___ Medical Records
___ Diagnostic & Laboratory Testing
___ Conversation
___ Other _____

Regarding services rendered during the following dates: _____

The purpose of this disclosure is:

___ Treatment ___ Legal ___ Disability ___ Family involvement

Other: _____

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Mood Treatment Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. Also, the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

I understand that this authorization for disclosure is voluntary and that I need not sign this form to ensure healthcare treatment.

❸ Signature and expiration (choose an expiration date far in the future if you don't want it to expire)

This authorization will expire on _____ (if blank it expires 12 months from the date signed)

Signature of patient: _____ Date_____

Signature of parent/guardian if under 18: _____ Date _____

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