Authorization for Disclosure of Information

** indicates a required field*

*** I hereby authorize and direct (enter name of clinician):**

*** To:**

- [ ] DISCLOSE the following information:
- [ ] EXCHANGE the following information:

*** 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.

* **Signature:** _____

I consent to sharing information provided here.

*** Name:**

*** Date:**