AUTHORIZATION FOR RELEASE OF MENTAL/BEHAVIORAL HEALTH RECORD

(Also known as Protected Health Information)

PATIENT NAME: _____

Date of Birth: _____

Address (Mailing): _____

Phone: _____

I authorize Dr. Meg Earls, Psy.D. to use or disclose information from my mental health record, which may include information about psychiatric diagnosis and treatment to:

Name: _____

Purpose of Disclosure:

_____ For coordination of behavioral health care with other providers for optimal treatment; and/or

_____ (other, specify reason): _____

1. I understand that, unless withdrawn, this authorization will be valid so long as I am in treatment with these providers. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Dr. Meg Earls in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
4. I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____

Signature of Patient or Authorized Parent/Legal Guardian Date

_____ _____

Written name Relationship to Patient