Authorization to Disclose Information

I, undersigned, _____
First and last name

Residing at _____
Home Address

_____ _____
Email Address Phone Number

As _____
Person receiving services, parent(s), legal representative

Authorize _____
Name of the organization and/or the mental health professional

To disclose to _____
Name of the organization and/or the mental health professional

_____ _____
Email Address Phone Number

The following information:

- ❑ Assessment report
- ❑ Progress notes
- ❑ Summary report
- ❑ Other: _____

For treatment or services received within the following period:

_____
Dates

And regarding the information contained in the record of the following person:

Name: _____

Date of Birth: _____

Address: _____

This authorization is valid for a period of _____ days from the date of signature of this document.

To revoke this authorisation, please send a written request to the concerned mental health professional.

_____ _____
Signature of authorized person Date

_____ _____
Witness signature Date