Focus C³
Counseling, Coaching & Consulting

AUTHORIZAITON FOR RELEASE OF MENTAL HEALTH RECORD

(Also known as Protected Health Information)

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows Focus C3, PC to release and/or exchange your protected health information. You can revoke this authorization at any time by submitting a request in writing to the agency. Revoking this authorization will not affect any action taken prior to receipt of your written request. I understand this authorization will expire 360 days from the date signed. Note: Psychotherapy (Session) notes may not be included in this authorization along with any other protected health information.

PATIENT NAME _____ Date of Birth _____

Address (Mailing) _____ Phone _____

_____

I authorize Focus C3 PC to release _____ (initial) and/or receive _____ (initial)information for my mental health record, which may include information about psychiatric diagnosis and treatment and substance abuse issues to:

Name: _____ Phone _____

Address: _____ FAX _____

_____

Dates of Treatment: _____

Information to be released:

- o All Information necessary for coordination of care
- o Psychological Testing/Psychiatric Assessment
- o Initial Intake/Discharge Summary
- o Other: _____

Purpose of Disclosure _____

Expiration (when this release will end): _____

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

_____ _____

Signature of Patient or Parent/Legal Guardian/Authorized Date

_____

Relationship to Patient

_____ _____

Signature of Witness Date

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