AUTHORIZATION TO DISCLOSE PROTECTED MENTAL HEALTH INFORMATION

Amy Robertson, LCSW Amy Robertson LLC

Patient Name: SSN:
Address: Birthdate:
Telephone: Identity Code:

Healthcare Information From:	Release to:

I authorize the above-named health care provider to disclose the privileged information specified below to the organization, agency, or individual named on this request:

INFORMATION REQUESTED:

Place/Dates of Service:

Kind and amount of information to be disclosed:

Purpose of disclosure/why information required:

I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

AUTHORIZATION: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer or their designee. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. **This authorization expires six months after termination of treatment with Amy Robertson, LCSW.** If I have authorized disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be valid as the original.

I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for any copy of my health record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the facility privacy officer or their designee.

Signature: _____ Date: _____
Patient (Parent or Guardian if patient is a minor)
Minor's signature is required for release of any records for treatment which the minor may authorize.
RELATIONSHIP (if other than patient): _____
IDENTIFICATION OF PATIENT OR DESIGNATED REPRESENTATIVE
☐ Drivers License # _____ ☐ Passport # _____
☐ State ID # _____ ☐ Other ID # _____