authorization to release mental health information

I____ DOB _________________authorize Arches Counseling and Trauma Treatment to release my personal and protected health information to individual or organization____________________________

via

☐in person
☐fax ____
☐email ____
☐written____
☐telephone ____

specific nature of information to be released:

☐any or all of the following
☐attendance/scheduling/transportation
☐payment information
☐presenting issues/chief complaints
☐assessments
☐other __________________________
☐diagnosis
☐treatment recommendations
☐treatment plan and goals
☐response to treatment/progress
☐summary of treatment

purpose of information being released ____

This release will **expire** on ________________________________ , or one year from the date of signature, whichever is sooner. I understand that I may revoke this authorization at any time for any reason in writing or via email.

____
printed client name

____
printed legal guardian name

____ ______________________
client or guardian signature date

____ ______________________
witness date