LEIGH ANNE MEHLDAU, LCSW
Licensed Therapist/Certified Divorce Mediator
200 Oak Street, Suite D
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Authorization to Release Personal Health Information (PHI) and/or Mental Health Records

I, _____ authorize **Leigh Anne Mehldau, LCSW** to obtain and/or release the following Personal Health Information to assist in the treatment process:

_____ Verbal Contact _____ Letter (Specify) _____
_____ Health/Medical Information
_____ Treatment Summary
_____ Evaluations, Court-Ordered Documentation, Treatment Plan, etc.
_____ Educational Records (Evaluations, Testing, Individual Education Plan (IEP)
_____ Information and Authorization Form to be faxed

From the record of _____
Client Name (please print clearly) **Date of Birth**

To/From:
_____ Primary Care Physician (***Required)** _____ Psychiatrist _____ Therapist/Mental Health Provider
_____ School Personnel
_____ State Agency (Specify) _____
_____ Attorney
_____ Other

Name(s): _____

Address: _____

_____

Telephone Number: _____ ***Fax Number:*** _____

This Personal Health Information will be obtained/released for the purpose of:
_____ Coordination of Services and Treatment Planning _____ Risk Assessment and Safety Planning

This Information is pursuant to the Privacy Act of 1974 (CT State Statute Chapter 899 and P.L. 93-679). I understand that the PHI or record to be obtained/released may contain information pertaining to psychiatric, drug and/or alcohol diagnosis, and treatment. I understand I may withdraw this consent at any time in writing prior to the release of the above information. This consent, if not withdrawn, will expire one (1) year from the date below.

_____
Client Signature Date

_____
Parent/Legal Guardian Signature Date

_____
Witness Signature Date