VR Behavioral Health Services

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Authorization To Release Information

I,_____,(hereinafter "Patient") hereby authorize _____ (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of evaluation and/or psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:

Name:_____
Address:_____
Phone:_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of his authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose (s):

Such disclosure shall be limited to the following specific types of information:

The above noted information may be released either verbally and/or in writing.

This authorization shall remain valid until: _____.

Patient's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____