Joseph T. Wilkinson, LICSW
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Authorization for Disclosure of Mental Health Treatment Information

I, _____ [Patient/Client Name], DOB: _____/_____/_____, authorize Joseph T. Wilkinson, LICSW to disclose to and/or obtain information from:

Name/Title/Organization: _____

Information to be Disclosed (Initial):

_____ Assessment _____ Diagnosis _____ Psychosocial Eval _____ Psychological Eval _____ Psychiatric Eval _____ Tx Plan/Summary _____ Tx Update _____ Medication Info
_____ Participation _____ Medical Info _____ Educational Info _____ Discharge Summary
_____ Continuing Care _____ Progress _____ Demographics _____ Psychotherapy Notes*
_____ Other: _____ _____ Other: _____

Purpose of Disclosure:
_____

I understand that I may revoke this authorization in writing at any time by contacting Joseph T. Wilkinson, LICSW at the address above. Revocation will not apply to disclosures already made.

This authorization expires on: _____ OR upon the following condition/event:
_____
__

Signature of Patient/Client: _____ Date: _____

Signature of Parent/Guardian/Rep: _____ Date: _____

Authority (POA, Guardian, etc.): _____

☐ Patient/Client refuses to sign

Staff Witness Signature: _____ Date: _____