



Client's Full Name

Date of Birth

RELEASE OF INFORMATION

I authorize THE MENTAL HEALTH STOP to: Receive or Release the following health, and or protected health information:

- | | | |
|---|---|--|
| <input type="checkbox"/> Biopsychosocial Assessment | <input type="checkbox"/> Treatment Plan/Goals | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Appointment History | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Evaluations/Exams | <input type="checkbox"/> Statements/Invoices | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> HIV/AIDS/STD/STI | <input type="checkbox"/> Educational Records |
| <input type="checkbox"/> All records | <input type="checkbox"/> Restricted Verbal Communication* | |
| <input type="checkbox"/> Other: _____ | | |

*Restricted Verbal Communication only discloses non-health related information such as appointments or payment

From Date

To Date

Name of Person/Entity Information

Phone Number

Address

City

State

Zipcode

Format: Mail out Fax Pick up Phone Email

Expiration: I understand that I may cancel this authorization at any time by sending THE MENTAL HEALTH STOP my notice of cancellation in writing. I understand that THE MENTAL HEALTH STOP may have already used or released records according to this authorization prior to receiving my notice of cancellation. Unless cancelled, this authorization expires on: _____
Or when the following occurs: _____

Check one of the following in the event of your death...

- I authorize the above person to obtain my health records as described above.
 I do not authorize the above person to obtain my health records.
 N/a

I understand this this authorization to release health records is voluntary and that I may refuse to sign this authorization, signing this authorization is not a condition of the client receiving treatment. I have read and understand this authorization form. I am the client or I am the client's legally authorized representative to execute this authorization and accept these terms.

Signature

Date Signed

Time

Print Name & Relationship if not the Client