Resilience & Transformation
PSYCHOTHERAPY CENTER

Authorization for Release of Confidential Mental Health Records

Client Name: _____ Date of Birth: ____/____/____

I authorize Resilience & Transformation Psychotherapy Center to release information to the following:

Name(s) _____

Organization: _____

I understand that I have the right to inspect and copy the information to be disclosed. And that I may revoke this authorization at any time by written notification.

Consequences of a refusal to consent are as follows:
❒ Information will not be released ❒ Other_____

The purpose of this disclosure is:
❒ Continuity of care ❒ Legal ❒ Employment ❒ School
❒ Other _____

The nature of the information to be disclosed is as follows:
❒ Personally identifying information ❒ Psychotherapy notes
❒ Information shared in counseling sessions ❒ Telephone conversations
❒ Psychological exam &/or assessment results ❒ Treatment plans
❒ Medical records between Resilience & Transformation Psychotherapy Center and the partie(s) listed above.
❒ Other_____

The following exceptions apply: _____

Date Authorization Expires: ____/____/____

_____ _____
Signature of Client (if at least 12 years old) Date

_____ _____
Signature of Parent or Authorized Guardian if Minor is under 12 years old Date

_____ _____
Signature of Witness Date