



142 Main Street E. | Girard, PA 16417 | (814) 324-5373
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Authorization for Release of Mental Health Information

Name: _____ Date of Birth: _____

I authorize Anchor Point Counseling & Coaching to use and / or disclose my mental health information only as described below:

1. Anchor Point Counseling & Coaching is authorized to disclose / obtain my mental health and any other needed information to / from the following person and / or entity:

Name: _____

This document gives Anchor Point Counseling & Coaching the right to receive and give information and is reciprocal with the above-mentioned entity.

Please check and specify one of the following purposes for disclosure:

- Coordination of treatment Continuation of treatment Legal issues
 Obtaining benefits / assistance

2. This authorization covers the following health information about me:

- Psychiatric / psychological evaluations Summary of treatment Treatment plan Diagnosis
 Medication records Court order School records Verbal communication
 Other: _____

3. This authorization expires on: _____

I understand that I have the right to revoke this authorization at any time. I may not revoke it to the extent that Anchor Point Counseling & Coaching has already relied upon it or if this authorization was a signed condition of insurance coverage. In order to revoke this authorization, I understand I must revoke it in writing to Anchor Point Counseling & Coaching. I understand that the information being used or disclosed in this authorization could potentially be re-disclosed by the person receiving the information, and may no longer be subject to the privacy protections provided to me by law.

Printed Name: _____ Date: _____

Signature: _____ Witness Signature: _____