# AUTHORIZATION TO RELEASE INFORMATION

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

_____
_____
_____

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

**This disclosure of information and records authorized by Patient is required for the following purpose: _____**

**The specific uses and limitations of the types of medical information to be discussed are as follows: _____**
_____
_____

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

**Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.**

**Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state law may protect such information.**

**This authorization shall remain valid for one year from date of signature.**

**Patient's signature: _____**
**Date: _____**