ALLIED MENTAL HEALTH SPECIALTY GROUP
Authorization to Release Protected Health Information
Client Number Name (First, Middle, Last) Birth Date (Month, DD, YYYY)

Instructions: If any section is incomplete, this form may be invalid. Release, Obtain, or Exchange Information To/From Release, Obtain, or Exchange Information To/From Purpose of Release Treatment/Continued Care Personal Legal Purposes Application for Insurance Disability Determination Payment on Insurance Claim Other ____

Information to be Released Admissions/Intake Diagnostic Impressions Progress Notes Psychiatric Evaluations Academic Records/ School Functioning Discharge/Treatment Summary Social/Court Services Summary Psychological Testing/Evaluation Phone Consultation Laboratory tests Other ____ I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for the copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to the redisclosure by the recipient and may no longer be protected by federal law. This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: ________________ Signature (Required) Date Signed (Required) (Month, DD, YYYY) Printed Name of Person Signing (If Not Patient) Mailing Address of Client – Street City State ZIP Code Phone ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form. • If the patient is 18 years of age or older, the patient must sign and date the form. • If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. o Please indicate your legal authority and include documentation of your relationship: Legal guardian or Conservator Health Care Agent (Health Care Power of Attorney) • If the patient is 17 years of age or younger, the patient’s parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: Parent Legal Guardian