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# AUTHORIZATION FOR RELEASE & RECEIPT OF MENTAL HEALTH RECORD AND INFORMATION

(also known as Protected Health Information)

CLIENT NAME: _____ Date of Birth: _____

Address (Mailing): _____ Phone: _____

_____

I authorize Jennifer M. Ritter to obtain, use, or disclose information from my mental health record (et al), which may include information about psychiatric diagnosis and treatment and substance abuse issues to:

Name: _____ Phone: _____

Address: _____ FAX: _____

Dates of Treatment: All Dates of Treatment

Information to be released [*please describe*]: _____

_____

Purpose of Disclosure: _____

_____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by written notice to the address indicated above, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
5. I understand that I waive my rights to privilege under IRE 507 related to mediation communications and the mediation process.
6. My treatment and payment for my treatment will not be affected if I do not sign this Authorization.
7. I understand that I can request a copy of this Authorization after I sign it.
8. I HEREBY RELEASE JENNIFER M. RITTER FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION PURSUANT TO THIS AUTHORIZATION.

By signing below, I acknowledge that I have read and understand this Authorization.

**OR**

_____ _____

Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____

Relationship to Patient