Authorization for the Disclosure of Mental Health Treatment Information

Name: ____ Date of Birth: ___________________

I, the undersigned, hereby authorize Holistic Psychiatry CT to disclose and/or obtain information from:

Name: ____

Relationship to patient: ____

Address: ____

Phone: _________________________________ Email: ______________________________

Description of Information to be Disclosed:

- ☐ Psychiatric Evaluation, including diagnosis (if applicable)
- ☐ Medication history
- ☐ Progress Notes
- ☐ Physical exam findings, including diagnostic/lab reports
- ☐ Substance use history and treatment information

Purpose of Disclosure:

- ☐ Treatment and diagnosis
- ☐ Care Coordination
- ☐ Academic Support
- ☐ Other: ______________________________

I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. I also understand that if my records pertain to alcohol or drug treatment, their confidentiality is further protected by Federal Regulation (42 CFR Part 2) and may not be disclosed unless I have explicitly provided my consent above. I may revoke this authorization at any time by written request to Holistic Psychiatry CT. This authorization is valid until I revoke it or 60 days after I have completed treatment, whichever is sooner.

Signature of Client ____

Signature of Parent, Guardian, or Authorized Representative (if under 16 or required by court)

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Date ________________________