# Authorization For Disclosure Of Mental Health Treatment Information

I, ______________________________ [Patient/Client], whose Date of Birth is ______,

authorize ___________________________________ to disclose to and/or obtain from:

_______Angelique Saunders, LPC___________ the following information:

**Information to be Disclosed**

(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
______Nursing/Medical Information

_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
______Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
______Other_______________________
______Other_______________________

**Purpose**

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:

___________________________________________________________________________

**Revocation**
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Angelique Saunders, LPCC at allinstridecounseling@gmail.com, verbally, or in person. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**Expiration**
Unless sooner revoked, this authorization expires on the following date: ________________ or as otherwise indicated:_____________________________________________________________________________

**Conditions**
I further understand that Angelique Saunders, LPC will not condition my treatment on whether I give authorization for the requested disclosure.

___________________________________ ______________
**Signature of Client** **Date**

___________________________________ ______________
**Signature of Clinician** **Date**