MENTAL HEALTH INFORMATION RELEASE FORM

CONSENT & AUTHORIZATION TO USE, DISCLOSE, and RECEIVE MENTAL HEALTH AND MEDICAL INFORMATION

I, _____
First Name Last Name Any Known Alias

Hereby authorize Kera Glazer-Rosoff, Ph.D. to disclose information and records obtained in the course of my diagnosis and treatment, and to receive information about my diagnosis and treatment for the following purposes: to increase understanding of my previous history, diagnosis, and treatment; to coordinate care on an ongoing basis with other providers that are also treating me; or to discuss my care with friends or family that may be important sources of support.

Information is to be disclosed to:

Name of Individual/organization	Address	Phone number/Fax

I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by Kera Glazer-Rosoff, Ph.D. to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

I understand that I have the right to refuse consent and signing of this authorization and that Kera Glazer-Rosoff, Ph.D. shall not condition my treatment or the treatment of those under my care upon this refusal.

I understand that I am voluntarily signing this form to release my health information to the party or parties designated.

I understand 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 laws may protect such information.

This authorization is effective immediately and shall remain in effect for one year from date of signing unless explicitly revoked in writing.

Signature: _____ Date: _____
(Patient, parent, or legal guardian)

If parent or legal guardian:
Name: _____ Relationship to client:_____

Witness: _____