Authorization for Release of Mental Health Information

Client Name ______________________________ **Date of Birth** ________________

This authorization will expire:

___ When Information is received
___ In six Months
___ On date ____________
___ In one year
___ In Three Years

The person named above is or has been a client of:

Reach Counseling, LLC
873 Baxter Dr.
South Jordan, Ut. 84095

The client named above hereby authorizes Reach Counseling, LCSW to be in contact with:

Provider/organization ____________________________________
Address ____________________________________
____
____
Phone/fax ____________________________________

For the following:

___ Request Information
___ Discuss Health Information
___ Send Mental Health Information
___ Discuss Mental Health Information

Scope:
___ All information regarding assessment, diagnosis, and treatment of patient's condition, or concern.
___ All information regarding care received by patient between dates of _____________
Start date
And ________________.
Ending date

Authorization (parent/Guardian sign if client is a minor)

Print Name ___________________________ Relationship to client______________

Sign Name ____

Date _______________