

AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize <Mosaic Therapy> To release and disclose information from the clinical record of:

_____ (_____)
(Name of client/recipient of mental health services) (Date of birth)

to, and allow such information to be inspected and copied by:

(Facility/Provider)

(Address)

Nature of information to be disclosed: _____
(State specific nature of information to be disclosed)

For the purposes of _____
(State specific purpose of information to be disclosed)

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Mosaic Therapy NFP. I understand that a revocation is not valid to the extent that Mosaic Therapy NFP has acted in reliance on such authorization. This authorization is valid until _____.
(Date)

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): _____ no information released and/or _____.
_____.

A copy of this release shall have the same force and effect as the original.

(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.