MOSAIC THERAPY

Phone: (877) 691-7994 Email: info@mosaictherapy.org

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)

as needed and to allow such information to be inspected and copied by:

_____ at
(Name of Service Provider)

_____ _____
(Facility/Provider) (Phone Number)

_____
(Address)

Nature of information to be disclosed may include any/all medical, social, and/or mental health information necessary for treatment planning and case management for the purpose of treatment coordination.

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

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

_____ _____
(Client Signature if 12 yrs. or older) (Date)

_____ _____
(Parent/Guardian Signature) (Date)

_____ _____
(Witness) (Date)

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.