Beech Tree
Consulting &
Psychological Services

Authorization for Mutual Disclosure and/or Release of Confidential Information

Name of Patient | Date of Birth

I authorize _____ and/or the employees of Beech Tree Consulting and Psychological Services to release and/or exchange information in written, verbal, or electronic format with the individual or agency specified below.

I authorize the release of information to, the exchange of information with, and the receipt of information from:

_____
Name | Relationship to Patient

_____
Address

_____
e-mail address | Phone | Fax

The information to be disclosed is marked by an X:

___Name of therapist
___Diagnoses
___Treatment plan
___Other: _____
__Progress notes
___Treatment Recommendations
___Medications
___Psychological evaluation
___Treatment summary

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. Revocation of this authorization must occur by completing a revocation form and attaching it to this document. Per IN State Provision, this authorization will expire in 180 days (6 months) unless I voluntarily authorize this to remain in effect for 1 year or revoke this authorization in writing. This authorization expires on this date:

_____ (180 days from authorization) _____ (1 year from authorization)

Signature (signature of parent or legal guardian) | Printed name | Date

Mental Health Professional | Printed Name | Date

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