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	__Progress Notes	___Medications
___Diagnoses	___Treatment Recommenda-tions	___Psychological Evaluation
___Treatment Plan		___Treatment Summary

___Other: ____

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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