# Mind At Peace

*Mental Wellness Counseling*

## Authorization for Disclosure of Protected Health Information

### Client Information

Name: ______________________________________________________________

Address: ____________________________________________________________

Phone: ________________________________ Email: ________________________

### Release To / Obtain From

Name: ________________________ Relationship: ___________________________

Facility: (if applicable) ___________________________________________________

Address: ____________________________________________________________

Phone: ________________________________ Email: ________________________

### Information to be Disclosed – Verbally or in Writing

___ Psychological Findings

___ Treatment Plans

___ Personal Recovery Plan / Discharge Plan

___ Treatment Progress

___ Psychiatric Evaluation/Findings

___ Medications

___ Psychiatric/Psychological Test Results

___ Treatment Outcome

Information Not for Release: _____________________________________________

### Expiration

This authorization for release of client information expires on: ____________________

### Client Signature

________________________________ ____________________________

Signature Date