

# Informed Consent for Disclosure of Mental Health Records and Information

Client name: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I hereby authorize Tom Cloyd, M.S, to release:

<b>these materials:</b> <input type="checkbox"/> intake assessment/evaluation <input type="checkbox"/> medication review notes <input type="checkbox"/> other:	<input type="checkbox"/> progress notes <input type="checkbox"/> treatment plan	<b>purpose of information -</b> <input type="checkbox"/> treatment planning <input type="checkbox"/> treatment / referral coord. <input type="checkbox"/> other:	<input type="checkbox"/> legal issues <input type="checkbox"/> employment assistance
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**Information to be released to:** \_\_\_\_\_ Phone no.: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State / ZIP: \_\_\_\_\_

**I hereby authorize:** \_\_\_\_\_ Phone no.: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State / ZIP: \_\_\_\_\_

... to release to Tom Cloyd, M.S.:

<b>these materials:</b> <input type="checkbox"/> intake assessment/evaluation <input type="checkbox"/> medication review notes <input type="checkbox"/> other:	<input type="checkbox"/> progress notes <input type="checkbox"/> treatment plan	<b>purpose of information -</b> <input type="checkbox"/> treatment planning <input type="checkbox"/> treatment / referral coord. <input type="checkbox"/> other:	<input type="checkbox"/> legal issues <input type="checkbox"/> employment assistance
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*I understand that my records are protected under Federal and State Statutes and cannot be disclosed without my written consent, except as provided for in the law. This authorization expires in 90 days or upon termination of services provided by Tom Cloyd, M.S. I understand that this consent may be revoked at any time by presentation of a written revocation request to Tom Cloyd, M.S.*

Signature of client or legal representative \_\_\_\_\_ Date signed \_\_\_\_\_

Relationship / Status, if signed by other than client \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date release expires \_\_\_\_\_

**Special consent must be given to release specific information regarding the following:**

HIV/AIDS     Sexually Transmitted Diseases     Drug and/or alcohol abuse/dependence

Signature authorizes consent \_\_\_\_\_ Date signed \_\_\_\_\_

**Note:** A general authorization for release of information is not sufficient for release of mental health records and information. / For children under the age of 13, a parent or guardian must sign. Children or adolescents age 13 and older sign for themselves.

[consent form.dot / 20070602]

