Meridian Psychological, LLC PO Box 534 Sheridan, WY 82801 p. 307-461-9737 email:draturlington@gmail.com

**AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION**

This form will only be used for authorization to disclose mental health information as indicated below. Privacy Act of 1974 applies.

|  |  |
| --- | --- |
| Client Name: | Date of Birth: |
| SSN: | Period of Treatment (if applicable): |
| Reason for request:□ Personal Use □ Insurance□ Continued Medical/Mental Health Care □ School□ Legal □ Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DISCLOSURE**

|  |
| --- |
| I authorize  \_\_\_ *Meridian Psychological, LLC; PO Box 534; Sheridan, WY 82801; 307.461-9737; draturlington@gmail.com*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (organization/name & address)And  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (organization/name & address)To release information about me and my mental health care to each other as needed. |
| The following information (brief description): |
| I understand that:1. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my mental health records are kept. I am aware that if I revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
2. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
3. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act.
4. The condition of treatment, payment, or eligibility for care will not be based on a refusal to sign this form.
5. Future disclosures of the information without written consent of the person is prohibited.

**I request and authorize the named provider/treatment facility to release information described above to the name individual/organization indicated.** |

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| Signature of client/guardian Relationship to client (if applicable) | Date |
| Signature of witness | Date |

For staff use only (to be completed upon receipt of written revocation)

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| --- | --- |
| □ Authorization revoked | Date of revocation: |