Clayton Mental Health, L.L.C.

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Authorization for Release of Information

Name: _____ DOB: _____

Address: _____ Phone: _____

_____ Email: _____

☐ I authorize Clayton Mental Health, L.L.C., to release information to and obtain information from:

Name of Provider or Facility _____

Address _____

_____

Phone # (Include area code) _____

Email _____

PURPOSE OF REQUEST: ☐ Coordination of Care ☐ Support ☐ Other

TYPE OF RECORDS AUTHORIZED:
☐ Psychiatric/Psychological Evaluation and/or Treatment
☐ Dietetic Evaluation and/or Treatment
☐ Drug/Alcohol Evaluation and/or Treatment
☐ Other _____

SPECIFIC INFORMATION AUTHORIZED:

☐ Assessments	☐ Progress Notes	☐ Laboratory Test Results
☐ Diagnostic Impression	☐ Discharge Summary	☐ Treatment Plans
☐ Treatment Summary	☐ Other: _____	

I authorize the release and disclosure of the information described above with the individual or entity identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire one year from the day this form was signed. I may cancel authorization at any time by submitting a written request, except where a disclosure was previously made in reliance on my prior authorization.

Patient Signature: _____ Date: _____

Clayton Mental Health, L.L.C. Signature: _____ Date: _____