ANCHOR OF HOPE

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORDS

Patient's Name: _____

RECIPIENT INFORMATION

I _____ am authorizing Anchor of Hope Counseling to ☐ release and/or ☐ obtain information from the mental health records for the patient indicated above to/from:

Name of Person/Facility: _____ **Phone:** ( ) _____

Email: _____ **Fax:** _____

Address: _____

_____

I authorize the following information may be released or obtained (please check all that apply):

- ☐ Entire Record
- ☐ Progress In Treatment
- ☐ General Updates on Progress
- ☐ Mental Health Assessment
- ☐ Psychotherapy Notes
- ☐ Behavior Updates
- ☐ Treatment Plan
- ☐ Progress in School
- ☐ Medication Information
- ☐ Other (Please Specify): _____

ACKNOWLEDGMENT OF UNDERSTANDING

By signing below, you are stating that you have read and understood this authorization. You also understand you may revoke this authorization at any time by notifying Anchor of Hope Counseling, and this authorization will cease to be effective on the date notified. A refusal to sign this authorization will not change your right to obtain present or future treatment.

Patient's/Guardian Signature: _____ **Date:** _____