MONARCH MENTAL
HEALTH AND WELLNESS

Release of Information Authorization _____ I do not wish to release information to anyone but myself

Client Name: _____ Client DOB: _____

Parent/Guardian Name: _____ Parent DOB: _____

Client authorizes Monarch Mental Health and Wellness to disclose the selected information to the following people:

1. Name: _____ Phone: _____ Relationship: _____
2. Name: _____ Phone: _____ Relationship: _____
3. Name: _____ Phone: _____ Relationship: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED

_____Assessment _____Diagnosis _____Psychological Evaluation _____Progress in Treatment
_____Current Treatment Update
__Present/Participation in Treatment to include appointment dates and times
_____Other_____

REVOCATION: I understand that I have a right to revoke this authorization, in writing, at any time by sending a written notification to Monarch Mental Health and Wellness administration at frontdesk@monarchmentalwellness.com I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

EXPIRATION: Unless sooner revoked, this authorization does not expire.

FORM OF DISCLOSURE: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem appropriate and consistent with applicable law and our Privacy Policy, including, but not limited to, verbally, in paper format, and electronically.

REDISCLOSURE: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Signature: _____ Print: _____ Date: _____

Signature of Parent/Guardian:_____Print: _____Date:_____