# ESSEX COUNTY MENTAL HEALTH SERVICES

P.O. BOX 8, 7513 COURT STREET
ELIZABETHTOWN, NY 12932
PHONE: (518)873-3670; FAX: (518)873-3777

## INFORMATION RELEASE AUTHORIZATION

NAME:________________________________ DOB:____________________ SS#:_______________________

I authorize Essex County Mental Health Services to: ______________obtain from ______________provide to:

Person or Agency: ________________ ______________________________________________
**(address)**

______________________________________________________________

______________________________________________________________

Phone________________________Fax_______________________________

the following information:

- ______ Treatment Plan/Summary
- ______ Psychiatric Evaluation
- ______ Psychological Testing
- ______ Progress in Treatment
- ______ Recommendations
- ______ Discharge Summary
- ______ Verbal Consultation
- ______ Other (specify)_____________________________________________________________
- ______ Academic Status/School Records
- ______ Educational Testing
- ______ Involvement in Program
- ______ Social/Family History
- ______ Physical/Medical History
- ______ Drug and/or Alcohol Evaluation

This information will be used for the following purpose(s):
______ Coordinating Care ______ Evaluation & Continuing Treatment ______ Other (specify)_________________________

This information is being released: ______ one time only ______ periodically as needed

For information being provided by or obtained from Essex County Mental Health Services, this authorization expires after one year unless otherwise specified below:

( ) 90 days following discharge from treatment ( ) will expire on __/__/____

( ) when following condition is fulfilled____________________________________________________________________

**I understand that the information to be released is confidential and protected from disclosure. I understand that this authorization can be revoked by a written statement at any time, except for action already taken.**

| ______________________________ | ____________________ | ____________________ |
|---|---|---|
| Signature of client/person acting for client | Relationship | Date |
| ______________________________ | ____________________ | ____________________ |
| Signature of Witness | Title | Date |

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***Cancellation of Authorization to Release Information***
***I hereby cancel my permission to release information to the person/agency listed above*:**

**Signature:** ________________________________________ **Date:** ____________________