AUTHORIZATION FOR RELEASE OF RECORDS

PATIENT'S NAME: _____ **DOB:**_____ **SSN:** _____

I hereby authorize:

_____ _____
AGENCY/FACILITY/PHYSICIAN/SCHOOL ATTENTION OF

_____ _____
STREET CITY/STATE/ZIP CODE

Phone:_____ Fax:_____

Its agents, employees, and/or servants to disclose my psychiatric and/or substance abuse records, and information obtained in the course of my diagnosis and treatment by them to:

DOGON MENTAL HEALTH
SECURELY UPLOAD DOCUMENT: WWW.DOGONMENTALHEALTH.COM

FOR THE FOLLOWING PURPOSES:

- ❑ CONTINUING CARE BY THE RECEIVING FACILITY/DOCTOR/THERAPIST
- ❑ TO ARRANGE FOR RESIDENTIAL TREATMENT
- ❑ ASSISTANCE BY THE RECEIVING AGENCY
- ❑ OTHER: _____

SUCH DISCLOSURE SHALL BE LIMITED TO THE FOLLOWING SPECIFIC INFORMATION:

- ❑ PSYCHIATRIC HISTORY & MENTAL STATUS EXAM
- ❑ PROGRESS NOTES
- ❑ RESULTS OF PSYCHOLOGICAL TESTS
- ❑ CONSULTATIONS
- ❑ OTHER (SPECIFY):_____
- ❑ MEDICAL HISTORY & PHYSICAL EXAM
- ❑ TREATMENT PLANS & UPDATES
- ❑ LAB & X-RAY REPORTS
- ❑ EDUCATIONAL ASSESSMENT & REPORTS
- ❑ TREATMENT SUMMARY

This consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance thereon and if not earlier revoked it shall terminate one year from the date of signing. Release or transfer of the disclosed information to any person or entity not specified herein is prohibited by law. An additional consent must be obtained for further usage or transfer of disclosed information. **I understand that I have the right to receive a copy of this authorization if I so request.**

I am fully aware that certain State and Federal Statutes and Regulations require that I voluntarily and knowingly sign this document before _____ can release any records, and that I may refuse to sign my signature, but in that event the record cannot and will not be released or disclosed by _____.

Dated: _____ _____
SIGNATURE OF PATIENT

Dated: _____ _____
SIGNATURE OF PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE OF PATIENT (indicate which)

Dated: _____ _____
WITNESS

NOTICE OF REVOCATION

I, _____, hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Signature of Patient/ Parent/
Guardian/Legal Rep: _____ Date: _____

Signature of Witness: _____ Date: _____