

COMPASSIONATE MENTAL HEALTH NURSING INC.  
Address: 5050 Palo Verde St, Suite 103I, Montclair, CA 91763  
Phone: (714) 262-4778 | Fax: (863) 228-8446

## Authorization to Release Mental Health Information

### 1. Patient Information

Full Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

### 2. Release Information To

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

### 3. Information to Be Released

I authorize the release of the following mental health information:

- Psychiatric evaluation
- Progress notes
- Medication list
- Other: \_\_\_\_\_

### 4. Purpose of Disclosure

- Continuity of care
- At patient request
- Other: \_\_\_\_\_

### 5. Patient Rights and Acknowledgment

- I understand that I may revoke this authorization at any time in writing.
- I understand that this release is valid for 1 year from the date of signature unless otherwise revoked.
- I understand that once information is released, it may no longer be protected under HIPAA.
- I understand that I am not required to sign this form and that treatment will not be withheld if I choose not to.

**6. Signature**

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient (if not self): \_\_\_\_\_

Signature of Patient or Legal Representative: \_\_\_\_\_