Authorization for Release of Mental Health Information via Electronic Transmission

Patient Name	Date of Birth	Patient ID#
Patient Address		

I request that health information regarding my care and treatment be released as set forth on this form. I understand I have the right to revoke this authorization at any time by contacting HPA in writing. I understand the risks of sending this information electronically.

Name & Address of Provider or Entity to Release this Information:		
Name & Address of Person(s) to Whom this Information Will Be Disclosed:		
Information from Dates of Care:	Start Date	End Date
Purpose for Release of Information		
I request this Authorization to be valid and in effect until		End Date

Comments:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Signature of Patient/Guardian	Date Signed
Printed Name	If not patient, relationship to patient