Community Connections
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AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH INFORMATION

I, _____, hereby request that the following information:

_____

_____

be disclosed by my physician or other mental health professional to :

_____

In authorizing this disclosure, I understand that this information will be used solely for the purpose of my coordination of care both now and in the future, and that this authorization for disclosure is limited to information that is now in existence.

I understand that I have a right to inspect my record of mental health information.

I further understand that this information cannot be disclosed or redisclosed without my authorization and that the law requires the following notice relative to mental health information.

The unauthorized disclosure of mental health information violates the provisions of the DC Mental Health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization by the client, or as provided in Titles III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.

This consent is subject to revocation in writing at any time. If not revoked by writing, this authorization shall expire _____ (no later than one year from date below).

_____ _____
(signature of client) (date)

_____ _____
(signature of witness) (date)