Notification of Extension for Use of Mental Health Care Information

(Practitioner/Provider/Clinic) _____

(Address) _____

_____

(Phone)_____

PATIENT INFORMATION:

Patient's last name _____ First name _____ M.I. _____

Date of birth / Former name, if any _____

REQUESTING ENTITY:

(Name)

_____

(Address)

_____

(Phone)

_____

INTENDED USE OF INFORMATION:

This information will be used for:

_____

_____

EXTENSION TIMEFRAME REQUESTED AND DESTRUCTION:

We request an extension for use of this information for:

☐ 30 days ☐ 60 days ☐ 90 days ☐ Other – Specify

Reason for Extension:

_____

_____

Prior to, or not less than three days after, the prescribed timeframe all mental health information obtained, and any copies made subsequently, will be destroyed or disposed of, caused to be destroyed or returned to the originator in a manner that preserves the confidentiality of the information contained therein.

CONFIDENTIALITY

All mental health information obtained will remain confidential and will be used solely for the purpose(s) described above and for no other purpose.

Signature of requestor_____ Date _____

For Clinic Use Only:

Date Received_____ I.D. provided _____
Date Released_____ Processed by _____

☐ Sent by mail ☐ Picked up in person