Request for Release 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 _____

1. REQUESTING ENTITY

Name _____

Address _____

Phone _____

2. REASON FOR REQUEST

I request the following mental health information regarding the above patient's outpatient treatment with a psychotherapist (as defined by Section 1010 of the California Evidence Code). Please be specific:

_____

_____

3. INTENDED USE OF INFORMATION

This information will be used for:

- ☐ Further medical care
- ☐ Payment of insurance claim
- ☐ Other
- ☐ Applying for insurance
- ☐ Vocational rehab evaluation
- ☐ Disability determination
- ☐ Legal investigation

4. TIMEFRAME FOR USE AND DESTRUCTION

This information will be kept for:

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

Justification for timeframes longer than 90 days _____

_____

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 in #4 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