Mary A. Donnelly, MA, LPC, LMHC
2804 Del Prado Boulevard South Suite 109
Cape Coral, FL 33904
(239) 989-9738 Phone
(866) 582-5875 Fax

Authorization to Release/Obtain Mental Health Information

Date:_____

Patient Name:_____

Date of Birth:_____**Social Security Number**:_____

I hereby authorize **Mary A. Donnelly, MA, LPC, LMHC** to disclose and/or request information to/from, specify name, address, fax number if applicable:

_____

_____

_____

Method of Disclosure: ____Verbal ____Written ____Fax ____Email
Purpose of Disclosure: ____Coordination of Care ____Legal Matter
____Other:_____

Information to be Disclosed/Requested:

____Clinical Assessment
____Treatment Recommendations
____Psychiatric/Psychological Evaluation
____Medication History/Evaluation
____Academic Records
____Medical History/Physical
____Diagnosis
____Treatment Progress/Discharge
____Psychological Testing
____Progress Notes
____Court Records/Documents
____Laboratory Results
____Other: _____

I expressly authorize information concerning the following to be released:

____Drug/alcohol treatment/abuse ____HIV/AIDS/ARC ____Mental Health Treatment

Notice to recipients receiving drug/alcohol abuse treatment records:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient.

I understand that this authorization will remain in effect for one year from today's date_____.
I understand that if Mary A. Donnelly, MA, LPC, LMHC is requesting the authorization for her own use, it will not condition the treatment, payment, enrollment in a health plan, or eligibility of benefits on my providing authorization for the requested use of disclosure.
I understand that I may request a copy of this signed authorization. A photocopy of this release is valid to the same extent as an original. I further understand that I may refuse to sign the authorization. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law. I understand that I can, at any time, change my decision and revoke my authorization, in writing, for releasing/requesting information as noted on this form.

_____ _____
Client Signature Date

_____ _____
Legal Representative (If Necessary) Date

_____ _____
Mary A. Donnelly, MA, LPC, LMHC Date