AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL MENTAL HEALTH INFORMATION

Patient Name:_____ Date of Birth: _____

Ann Behringer, L.C.S.W and _____ are hereby authorized to mutually release and disclose any and all information pertaining to the above named patient.

This authorization shall become effective on ___/___/___ and will expire in one year.

A photocopy or facsimile of this form is to be considered as valid as the original.

Upon request, you have the right to receive a copy of this Authorization.

Signature of Patient: **Date:**

_____ _____