MOUNTAIN VIEW
MENTAL HEALTH
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Authorization to Release Protected Health Information

Patient Name: _____ Date of Birth: _____

Previous Name, if applicable: _____ SSN: _____

I, _____, hereby **authorize** Mountain View Mental Health, LLC to **release** the protected health information pertaining to the care and treatment of the patient listed above. Additionally, I authorize the disclosure of the specified information below from the patient's medical record. I request and authorize the following person or entity to receive this information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This authorization applies to the following protected health information (check all that apply):

- ☐ Records specific to the following provider or location: _____
- ☐ The entirety of the patient's medical record
- ☐ Limited to the following dates of treatment: From _____ to _____
- ☐ Laboratory/Pathology Reports
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ All Mental Health Information
- ☐ Billing Information
- ☐ Other: _____

I understand that this authorization is voluntary and I may revoke this authorization at any time by sending written notice of my revocation to the address shown above. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before my written notice of revocation was received. Otherwise, this authorization expires after one year of signature. I understand that my provider will not condition treatment on whether I sign this authorization. I acknowledge that I may be charged reasonable fees for copies of this information.

By signing below, I acknowledge that I have had full opportunity to read and consider the contents of this authorization and agree to the uses and disclosures of the information described.

Signature of Patient or Legal Representative: _____

Patient Printed Name: _____ Date: _____