Arise Mental Health
arisementalhealthservies@gmail.com
(416) 670-8069

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I understand the information released may be subject to release by the person(s)/ agency receiving it and no longer protected by the federal privacy regulations

Client's Name. ____ Date of Birth. _______________

Address____. Postal Code_______________

I request and authorize Arise Mental Health to receive and/or release healthcare information of the client names above to:

Agency/Individual. ____

Address _________________________ City ______________ Province__________ Postal Code ______

Phone ___________________ Fax _______________________ Email ___________

For purpose of: Clinical Assessment Collaboration between Mental Health Providers and/or Medical Health Providers Concerned Family/Friend Other

Information will be released by: Verbal Phone Written Email Fax

This requisition and authorization applies to: (Select all that apply) All records & Ongoing Communication OR Diagnostic reports, Treatment plans, Progress Reports, School Records, Testing Results, Medical History, Case Records, Family History, Chemical Health, Psychiatric Evaluation, Discharge Summary, Appointments/ Fees, Other

I have been advised about and understand the following:

1. The specific information that is going to be released
2. The risks and benefits of releasing confidential information
3. That information may not be able to be controlled once it has been released and can potentially open up access to all my confidential information held by the therapist
4. The method by which the information will be released (e.g., copied documents sent my email, phone, email, etc) and the risks of such method of communication

I understand this consent expired one year from the date of signature unless I revoke this authorization by notifying Arise Mental Health, in writing of my decision to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on the action taken by Arise Mental Health in reliance on it before I revoked it. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment. A copy of this authorization will be treated in the same manner as the original.

Client or Guardian Signature. ____ Date: _________________

Therapist Signature____ Date: ___________________