

LOCAL FORM 2.

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL
MENTAL HEALTH INFORMATION**

I, _____, hereby authorize _____
_____ to release the following information relating to mental
status.

Complete copy of medical records _____

Test results _____

Other _____

To the following:

For the purpose of:

Continuing medical care

Disability determination

Insurance Claim

Other _____

I understand that I may revoke this authorization at any time except to the extent that action has
already been taken in reliance hereon. If not revoked sooner in writing, this authorization will expire
ninety (90) days from the date signed.

