

**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:**

\_\_\_\_\_

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