Jennifer Walrod, MSW, MPA, LCSW

111 Hillcrest Loop, Missoula, MT 59803
(406) 529-7776
www.jenniferwalrod.com
~~~~

# Request and Authorization to Release Mental Health Information/Records

**Client Name:**_____

**Date of Birth:**_____

____ I authorize Jennifer Walrod, LCSW, PLLC to release records TO (select all the apply):

____ Self ____ Other

Name:

_____

Address:

_____

City, State and Zip Code:

_____

Phone:_____

Fax:_____

____ Mail the Records ____ I will pick up the records

____ Fax the Records ____ Verbal Consultation Only

The Purpose of this disclosure is FOR:

____ Continuation or Coordination of Care

____ Attendance Verification

____ Application for Academic Accommodations

____ Medical Withdrawal

____ Litigation/Criminal Proceedings

____ Application for Employment

____ Other (specify):

_____

_____

_____

**Dates of Treatment:**_____
~~~~

Information to be disclosed is **limited** to:

___ Attendance Records

___ Diagnosis

___ Billing Record

___ Treatment Plan

___ Treatment Summary

___ Treatment Planning

___ Discharge Summary

___ Re-admission Recommendations

**I understand:**

- That I do not have to sign a release form nor am I obligated to release my information.
- Signing a release form is completely voluntary.
- This release is limited to what I write above. If I would like to release information in the future, I will need to sign another written, time-limited release.
- That information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- That Jennifer Walrod, LCSW, and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.
- My refusal to sign this release form will not jeopardize my right to obtain present or future treatment for mental health treatment.
- I may request a signed copy of this form.

***Expiration should not exceed six months.***

**This release expires on** _____
Date

**I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.**

**Signed:**_____ **Date:**_____

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 DFS, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for the release of medical information is not sufficient for this purpose.