APPENDIX N
CONFIDENTIALITY RELEASE FORM FOR PATIENTS

I, _____
(Patient's Name)

authorize _____ to release my
(Keeper of Patient's Psychiatric Records)

psychiatric medical records solely to:

_____
(Name and Address of Party to Whom the Records Are to be Released)

_____

This authorization is valid for _____
(Time Period)

and is strictly for the purpose of _____
(Purpose of Release)

_____ _____
Patient's or Guardian's Signature Date

_____
Witness's Signature

[This is a general release of information form. Some states have specific release forms mandated by law so be sure to check.]