LIKEMIND Mental Health & Wellness, Inc.
51 Union Street, Suite 222, Worcester, MA 01608

Release of Information

I hereby authorize LIKEMIND Mental Health & Wellness, Inc. to:

To:
- Release information to:
- Obtain information from:
- Exchange information with:

Name: _____
Address: _____
_____
_____
Phone: _____
Fax: _____

The information requested or authorized for release or exchange pertains to (check all that apply):

- ☐ Outpatient psychotherapy
- ☐ School Records
- ☐ Psychological/Neuropsychological evaluations
- ☐ Financial disclosures
- ☐ Scheduling
- ☐ Psychiatric medications/notes

☐ REFUSED

This authorization is valid from this date _____, to the end of treatment. I may cancel this authorization by sending a written, signed, and dated request to the practice listed above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my clinician has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____
Patients Name Date of Birth

_____ _____
Patients Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date

Please save this form to your computer, and then click the submit button below. At the next screen, drag and drop your saved document onto the secure file transfer window.

CLICK HERE TO SUBMIT