## 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