More MH Counseling
Make More Happen

Disclosure of Mental Health Treatment Information

More MH Counseling, LLC.
750 East Ave., Suite LE
Pawtucket, RI 02860
(508) 499 - 8525
Email: moremhcounseling@gmail.com

I, _____, whose Date of Birth is _____, authorize More MH Counseling, LLC. and it's representatives to disclose to and/or obtain the following information:

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes
_____ All obtained health information
_____ Other: _____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to More MH Counseling, LLC. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires on the following date _____

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Signature of patient/Guardian: _____ Date:_____

Signature of witness: _____ Date: _____