

YALE UNIVERSITY HEALTH SERVICES  
DEPARTMENT MENTAL HEALTH & COUNSELING (MENTAL HYGIENE)  
17 Hillhouse Avenue  
PO Box 208237  
New Haven, CT 06520-8237

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

Also known as Protected Health Information

PATIENT NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address (Mailing) \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_

I authorize YUHS Department of Mental Health & Counseling to use or disclose information from my mental health record, which may include information about psychiatric diagnosis and treatment and substance abuse issues to:

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ FAX \_\_\_\_\_  
\_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Information to be released (Please describe) \_\_\_\_\_

Purpose of Disclosure \_\_\_\_\_

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Department of Mental Health & Counseling at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
5. My health care and payment for my health care at YUHS will not be affected if I do not sign this form.
6. I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

\_\_\_\_\_  
Signature of Patient                      Date                      OR                      Parent/Legal Guardian/Authorized Person                      Date

\_\_\_\_\_  
Relationship to Patient