Authorization for Disclosure Of Mental Health Treatment Information

I, _____, parent or guardian of _____

whose Date of Birth is _____, authorize Amitav R. Sen, MD to disclose to and/or obtain

from:_____ the following information:
[Insert Name of Person or Title of Person or Organization]

_____ Psychiatric Evaluation

_____ Diagnosis

_____ Treatment Plan or Summary

_____ Current Treatment Update

_____ Educational Information

_____ Psychotherapy Notes

_____ Other_____

_____ Other_____

This information may be used or disclosed in connection with mental health treatment or healthcare operations.

I understand that I have a right to revoke this authorization at any time by sending written notification to Dr. Sen at amitavrsenmd@gmail.com. I further understand that a revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization. Unless sooner revoked, this authorization expires upon conclusion of treatment with Dr. Sen. I further understand that Dr. Sen will not condition my treatment on whether I give authorization for the requested disclosure.

Unless you have specifically requested in writing that the disclosure be made in a certain format, Dr. Sen reserves the right to disclose information as permitted by this authorization in any manner that he deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

_____

Signature of Patient/Client and Date

_____

Signature of Parent, Guardian or Personal Representative and Date

_____

Signature of Staff Witness and Date