Colonial Health Center

AUTHORIZATION TO DISCLOSE MENTAL HEALTH INFORMATION AS SPECIFIED IN THE DISTRICT OF COLUMBIA MENTAL HEALTH INFORMATION ACT OF 1978

I authorize Mental Health Services at the George Washington University Colonial Health Center to disclose the following information *(check all that apply):*

- ☐ Entire mental health record
- ☐ Dates on which services were received
- ☐ Intake & termination statements
- ☐ Diagnosis
- ☐ Assessment / testing
- ☐ Treatment information
- ☐ Other *(please specify):* _____

to the following person(s) or organization(s):

Name(s): _____

Contact information: _____

The following information is EXCLUDED from this release *(describe if applicable):*

_____

_____

The purpose for which the above information is to be disclosed:

_____

_____

_____

This authorization is subject to revocation, except 1) where a separate authorization is executed in connection with my obtaining a life or non-cancellable or guaranteed renewable health insurance policy in which the case the insurance company will set its own date of expiration not exceeding two years from the date of the policy, and 2) where an authorization is executed in connection with my obtaining any other form of health insurance policy in which case the insurance company will set its own date of expiration not exceeding one year from the date of the policy.

This authorization expires 365 days from the date this form is signed, unless otherwise indicated below.

_____ _____ / _____

Signature of Client or Authorized Representative | Date signed / Expiration Date *(if <365 days)*

_____ _____

Name of Client or Authorized Representative *(please print)* | GW ID Number

_____ _____

Witness *(please print)* | Signature of Witness