

**AUTHORIZATION FOR DISCLOSURE**

**(DISTRICT OF COLUMBIA MENTAL HEALTH INFORMATION ACT)**

I, \_\_\_\_\_, hereby request that the following information:  
(please print)

\_\_\_\_\_ be disclosed by my physician or other mental health professional to: \_\_\_\_\_.

In authorizing this disclosure, I understand that this information will be used solely for the purpose of: \_\_\_\_\_.

both now and in the future, and that this authorization of disclosure is limited to information that is now in existence. I understand that I have the right to inspect my record of mental health information. I further understand that this information cannot be redisclosed without my authorization and that the law requires this notice:

*The unauthorized disclosure of mental health information violates the provisions for the District of Columbia Mental Health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization by the client, or as provided in Titles III or IV of that act. The act provided for civil damages and criminal penalties for violations.*

This consent is subject to revocation in writing at any time.

\_\_\_\_\_  
(Signature)

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
(Witness)

- Copies must be:
- (1) Provided to patient
  - (2) Included in patient record
  - (3) Accompany disclosures

Note: This information is not to be used in connection with obtaining life or health insurance.