AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION
DISTRICT OF COLUMBIA MENTAL HEALTH INFORMATION ACT

I,_____ , hereby authorize:

Dr. Todd S. Cox
2300 N Street, N.W., Suite 620
Washington, D.C. 20037
P: (202) 223-8530
F: (202) 223-8531

to release and to obtain the following information from my mental health or medical records:

history, evaluations, examinations, studies, diagnoses, formulations, and treatments

to and from the following individual(s)/agent(s):

_____

_____

In authorizing this release of information, I understand it will be used solely for the purpose of:

coordination/determination of care and treatment planning

both now and in the future.

I understand that I have a right to meet with my clinician to inspect my record of mental health information. I further understand that this information cannot be re-disclosed without my expressed authorization and that the law requires this notice:

The unauthorized disclosure of mental health information violates the provisions of 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 provides for civil damages and criminal penalties for violations.

This authorization releases Dr. Cox from any and all legal liability that may arise as a result of his compliance with my request. This consent is subject to revocation at any time except that action has been taken in reliance thereon.

My signature below attests to the fact that I have read this form, understand its content and request that the above information be released as specified.

_____
Signature of Patient/Guardian and Date

_____
Signature of Witness and Date