Authorization to Share Mental Health Records for Disability Insurance

Patient Information

Full Name:

Date of Birth:

Address:

Recipient Information

I hereby authorize the mental health provider named below to disclose my mental health records to the following insurance company for the purpose of disability insurance evaluation:

Insurance Company Name:

Insurance Company Address:

Provider Information

Provider Name:

Provider Address:

Information to be Disclosed

- Diagnosis
- Treatment Summary
- Progress Notes
- Date(s) of Service
- Other:

Purpose of Disclosure

This authorization is for the purpose of supporting my application and evaluation for disability insurance coverage.

Expiration

This authorization expires on:

Patient Rights

- I understand that I may revoke this authorization at any time by providing written notice to my provider.
- Revocation will not affect any disclosures made prior to receipt of the revocation.
- I understand that authorizing the disclosure of this information is voluntary.
- I understand that information disclosed may no longer be protected by privacy laws once released to the insurance company.

Signature

Patient Signature:

Date:
