



**My Rights**

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party. Under no circumstances, however am I required to authorize the release of mental health records.
  
- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Morrow and/or the individual or facility listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization.
  
- I am entitled to receive a copy of this Authorizatoin.

**Signature**

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Client or Client's Legal Representative

If signed by someone other than client, please state your relationship to the client: \_\_\_\_\_

Witness or Translator: \_\_\_\_\_