District of Columbia
Release of Mental Health Information for Outpatient Mental Health Treatment

This form is designed to authorize the disclosure of the mental health information listed below by the individual practitioner to determine entitlement and payment of claims for reimbursement. It is not to be used for in-patient or partial hospitalization.

Carrier or Appropriate Recipient:

CLIENT INFORMATION

CLIENT'S FIRST NAME

CLIENT'S DATE OF BIRTH ☐☐ / ☐☐ / ☐☐☐☐

MEMBERSHIP NUMBER

AUTHORIZATION NUMBER (If Applicable)

PRACTITIONER INFORMATION

PRACTITIONER ID# or TAX ID

PHONE NUMBER

PRACTITIONER NAME, LICENSE#, ADDRESS & PHONE (Fax optional)

Date Client First Seen For This Episode Of Treatment ☐☐ / ☐☐ / ☐☐☐☐

Status? ☐ Voluntary ☐ Involuntary

MULTIAXIAL DIAGNOSIS CODE (PLEASE COMPLETE ALL FIVE AXES)*

*DSM, ICD or Other Recognized Code

AXIS I Dx Code ☐☐☐.☐☐ Dx Code ☐☐☐.☐☐

AXIS II Dx Code ☐☐☐.☐☐

AXIS III (if relevant) _____

AXIS IV Severity of current psychosocial stressors ☐ None ☐ Mild ☐ Moderate ☐ Severe

AXIS V: GAF Score Highest Past Year ☐☐ Current ☐☐

Current Medications and prescribing practitioner (if applicable): _____

Reason for Continuing Treatment and Treatment Goals: _____

Prognosis (limited to estimated duration of treatment): _____

Authorization Request Details

Modality of treatment maybe conveyed via CPT code or by describing in the field provided below.

(Modality examples: individual psychotherapy, group psychotherapy, medication management)

CPT Code ☐☐☐☐☐ or Modality: _____

Frequency (once a week, etc.): _____

Requested Start Date of Authorization: _____/_____/_____

Complete this section only if a second CPT/Modality is needed.

CPT Code ☐☐☐☐☐ or Modality: _____

Frequency (once a week, etc.): _____

Requested Start Date of Authorization: _____/_____/_____

Client's Consent: By signing below, I agree to share this information with the designated 3rd party payer (administrator). I also understand that, "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 and IV of that Act. The Act provides for civil damages and criminal penalties for violations."

Signature of Client - **or** - _____ Date: _____

Signature of practitioner*: _____ Date: _____

***My signature attests that I have consent from the Client to release this information.**