Beech Tree
Consulting &
Psychological Services

Authorization for Mutual Disclosure and/or Release of Confidential Information

Name of Patient | Date of Birth

I authorize ______________________ and/or the employees of Beech Tree Consulting and Psychological Services to release and/or exchange information in written, verbal, or electronic format with the individual or agency specified below.

I authorize the release of information to, the exchange of information with, and the receipt of information from

RECORDS DEPOSITION SERVICE, INC.
Name | Relationship to Patient

PO BOX 5054
Home/Business Address | Apt/Ste

SOUTHFIELD | MICHIGAN | 48086-5054
City | State | Zip

REQUESTS@RECDEP.COM | 248-357-3330 | 248-357-3337
E-mail address | Phone | Fax

Name of Therapist ☐	Progress Notes ☐	Psychological Evaluation ☐
Diagnoses ☐	Treatment Recommendations ☐	Treatment Summary ☐
Treatment Plan ☐	Medications ☐	Other (*explain below*) ☑

PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. Revocation of this authorization must occur by completing a revocation form and attaching it to this document. Per IN State Provision, this authorization will expire in 180 days (6 months) unless I voluntarily authorize this to remain in effect for 1 year or revoke this authorization in writing. This authorization expires on this date (**choose one**):

______________ (180 days from authorization) ***OR*** ______________ (1 year from authorization)

Signature of Patient or Legal Representative | Printed Name | Date

Signature of Mental Health Professional | Printed Name | Date

6411 South East St. Ste A
Indianapolis, Indiana 46227

317 780 5750 phone
317 780 5755 fax

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