5560 Sterrett Place, Suite 201
Columbia, MD, 21044
p. (443) 546-4000
f. (443) 546-4005

Authorization to Release or Exchange Information

Patient Information

Clients Name: ____ Date of Birth: _____________________

Address: ____

Phone Number: ____

Other Party

The provider, agency, family member and/or other entities

Name of Person/Organization: ____

Address: ____

Phone Number: ____

Information To Be Released

I hereby authorize Collaborative Counseling Center to (please check all that apply)*

☐ Release Information to ☐ Gather Information from ☐ Exchange Information with

This information may consist of the following (please initial each line to which consent is given):

_______ Psychological test reports
_______ Psychiatric evaluation reports
_______ Periodic reports of psychotherapy
_______ Social History Data (family, education, employment, arrest, drugs, and alcohol)
_______ Medical Information
_______ Other (specify): ____

This information will be used (please initial each line to which consent is given):

_______ To determine appropriateness of treatment
_______ To develop a diagnosis and treatment plan
_______ To facilitate coordination of services
_______ At the request of the individual
_______ Other (specify): ____

Acknowledgment

I understand that no information may be forwarded by either party listed in this release to any other individual or agency without my written consent. I understand that this information may not be redisclosed by its recipient. This authorization may be revoked at any time by my written statement except to the extent that authorized persons who are to disclose the information described above have already taken action in reliance on it. It is automatically revoked 30 days after the termination of the therapeutic relationship or under the following conditions:

This consent is given voluntarily, without coercion. Signing this form is not required to receive treatment/services at Collaborative Counseling Center.

Sign: ____ Date: ____________________

If the authorization above is given on the patient's behalf because the patient is either a minor or unable to sign, please specify who signed below:

Name: __________________________________ Relationship to Patient: __________________________________