Chesapeake Bay Psychological Services LLC

Telephone: 410-604-0226 Facsimile: 877-643-0126
www.chesapeakebaypsychological.com

Authorization to Release Information

Client name:_____ DOB: _____

I hereby authorize the disclosure of my individually identifiable health information, as follows:

The Persons/Organizations indicated below are authorized to RELEASE and/or RECEIVE the information:

May RELEASE	May RECEIVE	
☐	☐	Chesapeake Bay Psychological Services LLC (CBPS)
☐	☐	Other(s): _____

Purpose:
- ☐ Coordination of Services
- ☐ Other: _____

Specific description of information to be released:

☐ Any and all information pertinent to mental health treatment

☐ Other: _____

- I understand that this authorization will expire one year from the date signed or earlier on _____
- Please note:
  - ☐ I am not required to sign this authorization in order to receive services at CBPS.
  - ☐ I am required to sign this authorization in order to receive the services I seek at CBPS,
    - ☐ because the information is necessary to complete the requested evaluation, and/or
    - ☐ because services were requested for the specific purpose of creating health information to be disclosed to _____
- I understand that this authorization is revocable except to the extent that action has been taken in reliance upon it. To be effective, any revocation must be received in writing by the party I have authorized to release the information.
- I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Client/Guardian Signature: _____

Printed Name: _____ Date: _____