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:

Chesapeake Bay Psychological Services and the person or entity listed below are authorized to RELEASE and/or RECEIVE my information:

Person/Entity's Name: ____

Contact information (phone, address, and/or fax):____________________________

Optional: List the Person/entity's email address here *only* if requesting that information to be released by email, which may not be secure:____

<u>*Purpose:*</u> Coordination of Services, or Other Purpose indicated in remarks below

<u>*Specific description of information to be released:*</u> Any and all information pertinent to mental health treatment, or only limited information indicated in remarks below

I understand the following:

- This authorization will expire one year from the date signed unless otherwise indicated below.
- I am not required to sign this voluntary authorization in order to receive services at CBPS unless otherwise indicated.
- 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.
- 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.

Remarks: ____

____

Client/Guardian Signature: ____

Printed Name: ____Date: ________________