CONSENT TO RELEASE CONFIDENTIAL INFORMATION
19560 Clubhouse Road Montgomery Village, MD. 20886

I, _____, Date of Birth_____, authorize

_____ to
Therapist

___Exchange ___Provide ___Receive

The following information about my treatment:

___ Psychological Evaluation

___ Treatment summary and progress

___ Diagnosis

___ Attendance

___ Discharge Summary

___ Emergency Contact

___Written and verbal communication

With the following person or agency:

Name _____

Address _____

Phone _____

For the purpose of _____

By signing below, I acknowledge my medical record is protected under State and Federal confidentiality regulations and others cannot disclose my information without my written consent unless otherwise provided for in those regulations. I understand this authorization is given in order to allow cooperation between the above persons or agencies only in regard to stated services or problems, and that I may revoke this authorization in writing at any time. I also understand that this permission will expire at one year from the date signed or completion of treatment, whichever occurs first. In consideration of this consent, I hereby release the above parties from any legal liability for release of this information.

_____ _____

Client Signature (Legal Guardian) Date

_____ _____

Therapist Signature Date