

Center for Anxiety & Behavioral Change

414 Hungerford Drive, Suite 252 | Rockville, MD | 20850 | 301.610.7850

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Authorization to Release Confidential Records and Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I, _____ hereby authorize:
(Print your name and date of birth)

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Rockville, MD, 20850
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To: Release Receive Exchange

The following protected health information:

- | | |
|---|--|
| <input type="checkbox"/> Intake and discharge summaries | <input type="checkbox"/> Medical history and evaluation(s) |
| <input type="checkbox"/> Mental health evaluations | <input type="checkbox"/> Developmental and/or social history |
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> Educational records |
| <input type="checkbox"/> Other: _____ | |

To/From: _____ (Print the name of the person or facility) _____ (Phone number)

Address: _____

For the following purpose(s):

- | | |
|---|---|
| <input type="checkbox"/> Further mental health evaluation, treatment, or care | <input type="checkbox"/> Rehabilitation program development or services |
| <input type="checkbox"/> Treatment planning <input type="checkbox"/> Research | <input type="checkbox"/> Other: _____ |

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 365 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

Signature of client Printed name Date

Signature of parent/guardian/representative Printed name, relationship Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

Signature of witness Printed name Date