Center for Anxiety & Behavioral Change

50 W. Montgomery Avenue, Suite 110 | 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)

Center for Anxiety and Behavioral Change
414 Hungerford Drive, Suite 252
Rockville, MD, 20850
301.610.7850

To: ❑**Release** ❑ **Receive** ❑**Exchange**

The following protected health information:
❑Intake and discharge summaries
❑Mental health evaluations
❑Progress notes
❑Other: _____
❑Medical history and evaluation(s)
❑Developmental and/or social history
❑Educational records

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

Address:_____

For the following purpose(s):
❑Further mental health evaluation, treatment, or care
❑Treatment planning ❑Research
❑Rehabilitation program development or services
❑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