THE COUNSELING
CENTER OF MARYLAND

8030 Woodmont Avenue, 3rd Floor | Bethesda, MD | 20814 | www.CounselingCenterofMaryland.com

Authorization to Release Information

Client's Name: _____

Date of Birth: _____

I hereby authorize: _____ (clinician name) of The Counseling Center of Maryland to release the following information:

- ☐ Counseling/psychtherapy reports
- ☐ Psychiatric reports
- ☐ Coordination of care information
- ☐ Medical/dental information
- ☐ Employment information
- ☐ School reports
- ☐ Psychological/educational testing reports
- ☐ Other non-health related information, specify _____

To:

Name: _____

Address: _____

Phone: _____

For the purpose of facilitating consultation, therapeutic treatment, and/or billing concerns.

Counseling Center of Maryland employees, associates, and volunteers have a duty to maintain the confidentiality of any information disclosed to them pursuant to this authorization. The client or authorized person may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, by providing written notice to the Counseling Center of Maryland.

I understand that authroizing the disclosure of this personal health information is voluntary. I need not sign this form in order to receive treatement.

_____ _____

Signature Date

Relationship of signee to client:

☐ Self ☐ Parent ☐ Guardian ☐ Power of Attorney