Thoughts & Emotions
MENTAL HEALTH THERAPY
7981 Eastern Avenue Suite C-5 Silver Spring MARYLAND 20910

Authorization for Release of Information

1. Client's Name:_____ DOB:_____

2. Information to be released:
   - ☐ Summary of treatment to date
   - ☐ Report
   - ☐ Other: _____

3. Purpose of Disclosure
   - ☐ Coordination of Care
   - ☐ Other:
     _____

4. Persons authorized to make Disclosure:
   _____

5. Person authorized to receive Disclosure:
   _____

6. Method of Disclosure
   - ☐ Written :_____
   - ☐ Verbal:_____
   - ☐ Electronic: _____

7. Today's date:_____Authorization to expire on:
   _____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization.

Should I choose to revoke this authorization I will state this in writing.

Signature of
Patient:_____Date:_____

Signature of Personal
Representative:_____