65 THOMAS JOHNSON DR. SUITE A • FREDERICK, MARYLAND 21702 • 240-651-5280

RELEASE OF INFORMATION TO AND FROM ANOTHER FACILITY

I hereby authorize Monocacy Start Center to obtain and release information about:

Client's Name: _____ Date of Birth: _____

to/from:

Organization: _____

Name: _____

Address: _____

_____

Phone number: _____

Fax number: _____

Purpose of release of information:

- ☐ ☐Further mental health care
- ☐ Treatment planning
- ☐ Other (specify): _____

_____

_____

Nature of the information to be released:

- ☐ ☐ Dates of Service
- ☐ ☐ Verbal exchange
- ☐ ☐ Treatment summary
- ☐ ☐ Full records
- ☐ ☐ Other (specify): _____

_____

This authorization and request to release or obtain information from my records is fully understood as to the nature of the records and information and the implications of its release and is made voluntarily on my part.

I understand that I may revoke this consent at any time within ninety (90) days except to the extent that action based on this consent has been taken. This consent will expire automatically after ninety (90) days from the date on which it is signed or upon the fulfillment of the above purposes or on / / _____.

I also know that I have the right to ask for and receive a copy of this authorization. I agree that a photocopy of this authorization will be as valid as the original.

_____ _____

Signature of Client or of Parent or Guardian Date

_____ _____

Signature of Clinician / Staff Date