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Federal ID # 52 1337356
MD Registration # 14839
MD State ID # D01620715
Maryland Charity Campaign
MCC # 4303
United Way CFC# 32593

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ___________________________________, hereby give my permission for the following releases of information by my therapist at the Pastoral Counseling Center of St. Mary's, Inc.:

Name of therapist: ____

Check the options that apply:

- ☐ To write or call the referring persons as a professional courtesy to let them know that I came for my appointment
- ☒ To release information to and/or request information from the following person(s):

Name of agency, hospital, doctor, or therapist: ____

Mailing Address: Street: ____

City, State, Zip: ____

(____) ______________________ Telephone Number

(____) ______________________ Fax Number

The items covered by this release are checked below:

- ☒ Intake Assessment
- ☐ Treatment Plan
- ☒ Attendance & Progress
- ☒ Recommendations
- ☒ Discharge Summary
- ☐ Other: ______________________________

This information is being released for the following reasons:
Coordination of services
____

- ☒ I understand that this release may include information regarding mental illness or substance abuse conditions.
- ☒ I understand that the information to be released is protected under state and federal laws that do not permit redisclosure without my further consent.
- ☒ I understand that I may revoke this authorization at any time, except for information that has been disclosed as a result of this authorization prior to its revocation. I understand that this authorization is voluntary and that I may refuse to sign it.
- ☒ This consent will expire ___365_______ days from the date it is signed.

______________________________ Signature of Client ______________ Date

______________________________ Signature of Parent, Guardian, or Authorized Representative ______________ Date

______________________________ Signature of Witness ______________ Date