Crawford Consulting and Mental Health Services, INC

"Healing Life through the Experience of Living"

AUTHORIZATION TO RELEASE INFORMATION

Client Name_____ DOB _____

Address _____

I _____ authorize **Crawford Consulting and Mental Health Services, INC (CCMHS)**

to release the following written and/or verbal information about me or my child's treatment at CCMHS to

_____.

Please check all that apply:

- ☐ **Intake Assessment Summary**
- ☐ **Psychological Evaluation**
- ☐ **Current psychiatric diagnosis**
- ☐ **Notification of beginning and/or ending of treatment**
- ☐ **Summary of Treatment Progress**
- ☐ **Treatment Planning**
- ☐ **Past Treatment**
- ☐ **Discharge Summary**
- ☐ **Educational Information/Records**
- ☐ **Financial Information**
- ☐ **List of current psychotropic medications and dosages**
- ☐ **Other (please specify):_____**

The purpose of the disclosure authorized herein is to (specific purpose of the disclosure):

_____

_____

_____

I understand that me/my child's therapist may be supervised and that the supervisor will have access to confidential information. I agree that the therapist's supervisor may substitute for the therapist in releasing information.

☐ **YES** ☐ **NO** ☐ **I do not wish for CCMHS to release information with anyone at this time.**

This consent for release of information is given freely, voluntarily, and without coercion, and may be withdrawn by me at any time. Any information I authorize other professionals to release to CCMHS will be held strictly confidential and will not be released without my written permission except as permitted by State or Federal Law. I understand that I have the right to inspect the record or mental health information on the above-named individual. This authorization is effective for one year from the date below.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Legal Custodian of Minor Date

_____ _____

Signature of Witness Date

6490 Landover Road, Suite E
Cheverly, MD 20785
Tele: 301-341-5111 Fax: 301-341-5211