Crawford Consulting and Mental Health Services

"Healing Life through the Experience of Living"

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

Completion of this form authorizes release of information described in the section below called "Specific Description of Record Authorized for Release". The person whose records are to be released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication/somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances.	Name: (Client) Address: City, State, Zip Code:
Social Security #:	Date of Birth:
Release Information From: Organization: Address: City, State, Zip Code:	Release Information to: Patrick Crawford, LCSW-C, LICSW Thomas Greene, MD, Komolafe Johnson, NP-H, Benjamin Adewale, MD Organization: Crawford Consulting and Mental Health Svcs, Inc Address: 6490 Landover Rd. Ste. E City, State, Zip Code: Cheverly, MD 20785 Phone: 301-341-5111 Fax: 301-341-5211

Specific Description of Records Authorized to be Released (include dates of records if applicable)

All medical records as it relates to client's mental health treatment. Including, but not limited to, session notes, treatment plans, psychiatric and psychological evaluations, testing and medication log/history, and current and preious medications

Purpose or Need for Release of Information (Be Specific)

Continued treatment of mental health services

Understandings:

♦This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefit eligibility except for:
____ No Exceptions _____ Exceptions:

♦The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the disclosed information may be controlled by different laws.

♦I may revoke this information, in writing, at any time for information already released as a result of this authorization. The written revocation must be given the agency/organization I authorized to release the information.

♦Unless revoked, this authorization will remain in effect until the authorization time listed below.

Chose One:
_____ Authorization expires as of: _____ (Date)

_____ Authorization expires __6__month(s) from the date I signed this authorization.

_____ Authorization expires after the following action takes place: _____

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

Signature – Person whose records will be released:		Date:
Signature – Other person legally authorized to consent to disclosure:	Title or Relationship:	Date:

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