FAMILY THERAPY
CENTER OF BETHESDA
Child, Teen, Family & Individual Therapy

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Authorization to Release & Disclose 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/receive Disclosure: _____

5. Person authorized to receive/make 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 Client: _____ Date:_____

Signature of Therapist: _____