HEALTHY SYNERGY
psychological services

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Germantown, MD 20876
301-569-6326 (office)
301-569-6329 (fax)
www.healthysynergypsych.com

Request Authorization to Release Confidential Records and Information

I hereby authorize Healthy Synergy Psychological Services, LLC to release information from records regarding:

Client Name: _____

Client DOB: _____

For the following purposes:

____ Further mental health evaluation, treatment or care

____ Rehabilitation program development or services

____ Treatment planning

____ To facilitate payment for services

____ Research

____ Other: _____

The information to be released is as indicated by a check mark:

____ Intake and discharge summaries

____ Mental health evaluations

____ Progress notes and/or treatment summary

____ Discharge summary

____ Medical History and evaluation(s)

____ Development of social history

____ Educational records

____ Other: _____

(see next page)

Select one of the following:

____ Forward the records to the address listed at the top of the first form

____ Allow consultation with: _____
Name

_____
Address

_____
Phone/Fax Number

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:

____ Do not release HIV-related information

____ Do not release drug and alcohol information

I fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequence and the implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer be protected by federal privacy regulations.

_____ _____ _____
Signature of client Printed Name Date

_____ _____ _____
Signature of parent/guardian/representative Printed Name Relationship

I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____ _____
Signature of professional Printed Name Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____ _____ _____
Signature of witness Printed Name Date

____ Copy for patient or parent/guardian ____ Copy for source of records ____ Copy of recipient of records