Bay Laurel Center for Psychotherapy

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client's Name: ____

Date of Birth: ____________________ Social Security Number: ____________________

I hereby authorize ____
(Name of person, agency, hospital, etc. releasing the information)

at ____
(Address of releasing party)

to disclose the following information about me: ____

____

to ____
(Name of person, agency, hospital, etc. receiving the information)

at ____
(Address of the receiving party)

for the purpose of ____

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The information about me to be released ____ **may** / ____ **may not** be transmitted by fax. The named releasing and receiving parties ____ **may** / ____ **may not** discuss by telephone the content of the information about me being released.

My authorization to allow this release of information is based upon my understanding of what is being released, of the use of the information once it is released, and my understanding that the party releasing this information cannot be held responsible for the protection of the privacy of this material once the information is transferred. I, therefore, release the provider of information from all liability arising from this disclosure. I understand that the party receiving said information is prohibited by federal law (Code of Federal Regulations 42, Part 2) from making any further disclosure of it without my specific written permission.

This consent is subject to revocation at any time except to the extent that disclosure has already been acted upon. If not previously revoked, this consent will terminate on upon compliance or upon ninety (90) days from the date signed.

____ ____________________
Signature of Client or Legal Representative Date

____ ____________________
Signature of Witness Date