10 West Madison Street #11
Baltimore, MD 21201

Complete Wellness
Complete healing for mind and body.

Phone: (443) 438-7863
Fax: (443) 957-9485

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name (Printed): _____ Date of Birth: _____

Information to be released for the purpose of providing clinical services to the client named above.

INFORMATION TO BE RELEASED

Information to be released about the client's treatment may include sensitive medical and personal information. Please talk with the clinician or with an administrator if you want to understand more about the information being released.

- ❑ School Performance Records (Grades, Tests, etc.)
- ❑ Psychosocial, Mental Health, and Medical History
- ❑ Confidential School Records (IEP's, etc.)
- ❑ Psychosocial Evaluations
- ❑ Medication Administration Records
- ❑ Mental Health Evaluations
- ❑ Physician Orders
- ❑ Psychological Testing Results
- ❑ Physical Examinations
- ❑ Neuropsychological Testing Results
- ❑ Radiology and EEG Reports
- ❑ Progress Notes
- ❑ Laboratory Reports
- ❑ Discharge Summaries
- ❑ Alcohol/Drug Abuse Treatment
- ❑ Consultation Reports
- ❑ HIV Related Diagnosis/Treatment
- ❑ Other, Specify: _____

Dates for Records to be Released: _____

AGENCY TO RECEIVE RECORDS

Agency: _____ Phone: _____

_____ Fax: _____

Address: _____

_____

Provider(s): _____

REVOCATION AND TIME LIMIT

I understand that I can change my decision to have this information released at any time unless the material has already been released by Complete Wellness. **This authorization is valid for one year after the date signed, unless otherwise canceled in writing by me prior to that time.** I authorize Complete Wellness to release the above indicated records to the agency listed above, and I agree to release Complete Wellness, its officers, directors, employees and associated professionals, clinicians, and therapists from any liability that arises from the release of this information to any individual or facility listed above.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Client over 15 years of age Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name (Printed): _____ Date of Birth: _____

Information to be obtained for the purpose of providing clinical services to the client named above.

PERMISSION TO SECURE INFORMATION

Clinician Requesting Information: _____

INFORMATION TO BE OBTAINED

Information to be obtained about the client's treatment may include sensitive medical and personal information. Please talk with the clinician or with an administrator if you want to understand more about the information being requested.

- ❑ Verbal Communication
- ❑ School Records (Grades, State Tests, etc.)
- ❑ Psychosocial, Mental Health, and Medical History
- ❑ Confidential School Records (IEP's, etc.)
- ❑ Medication Administration Records
- ❑ Mental Health Evaluations
- ❑ Physician Orders
- ❑ Psychological Testing Results
- ❑ Physical Examinations
- ❑ Neuropsychological Testing Results
- ❑ Radiology and EEG Reports
- ❑ Progress Notes
- ❑ Laboratory Reports
- ❑ Discharge Summaries
- ❑ Alcohol/Drug Abuse Treatment
- ❑ Consultation Reports
- ❑ HIV Related Diagnosis/Treatment
- ❑ Other (Please Specify):

Dates for Services Provided: _____

AGENCY RELEASING RECORDS

Agency: _____ Phone: _____

_____ Fax: _____

Address: _____

_____

Provider(s): _____

REVOCATION AND TIME LIMIT

I understand that this authorization is valid for one time only (for written records) or for one year (for verbal communication), unless canceled in writing by me before the material has been released to Complete Wellness. I authorize the agency listed above to provide records to Complete Wellness, and I agree to release Complete Wellness, its officers, directors, employees, and associated professionals, clinicians, and therapists from any liability that arises from the use of this information in the treatment of the above-named client.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Client over 17 years of age Date