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

1. If all highlighted areas are not completed, form is not valid and cannot be used.
2. If Fax Number is not available an address and phone number *must* be provided.

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

INFORMATION TO BE RELEASED

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

- ❑ Appointment schedule
- ❑ Payment Information
- ❑ 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
- ❑ Progress Notes
- ❑ Laboratory Reports
- ❑ Discharge Summaries
- ❑ Alcohol/Drug Abuse Treatment
- ❑ Consultation Reports
- ❑ Other, Specify: _____

Dates of service to be released: _____

I, the undersigned, hereby authorize _____ of Complete Wellness
(Name of Complete Wellness Clinician)

- ❑ to **release** the information indicated above **to**:
- ❑ to **obtain** the information indicated above **from**:
- ❑ to **discuss** the information indicated above **with**:

Individual Name: _____ Phone: _____

Agency Name _____ Fax: _____

Address: _____

_____

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 16 years of age or older Date