Authorization for Release/Exchange of Information

I hereby authorize _______________________________(Provider name) at

Contact Number: ____________________________ to release/receive the information initialized below which is contained in the record of:

Client Name:________________________________Date of Birth:_____________________
To/From Jayme Mahoney, Licensed Clinical MFT (LCM609MD, LMFT49992CA), 410.726.7709

I understand that the records and information to be released may contain information pertaining to psychiatric and psychological treatment and may contain confidential information.

The information released will contain those items necessary to coordinate treatment. This may include: psychological history, mental status and diagnosis, medical history, summary of psychological testing, progress notes, discharge summary and current/past medications.

This information is required to assist the above named professionals in determining the type of care needed. I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such disclosure. This consent form is freely given and I have not been threatened with discontinuance or refusal of services if I do not sign this form.

I understand that re-disclosure of the records and information specified herein to a third party may be necessary for the above sated purposes and authorize such a request.

I agree that the information may be exchanged via phone conversation, or via faxing of records, if necessary.

This authorization form shall be valid from ___________________ to ___________________.

____ _________________
Client/Parent/Guardian Signature Date

____ ____________________
Therapist Signature and License Number Date