Chesapeake Behavioral Health Center, LLC

217 Main Street, Suite B
Reisterstown, MD 21136
Tel: (410) 833-0581
Fax: (410) 833-8604

PLACE LABEL HERE

♦ CONSENT FOR RELEASE OF INFORMATION ♦

I (Full Legal Name), _____, Date of Birth: (_____/_____/_____)

hereby authorize Chesapeake Behavioral Health Center (CBHC), LLC to ❒ **RELEASE** / ❒ **RECEIVE** to / from the following information to/from the agency or person listed below.

This information is to be in the form of: ❒ written records ❒ verbal communication (*specify*) _____

This information is requested for the purposes of:
❒ Treatment planning ❒ Evaluation ❒ Case management ❒ Other (*specify*): _____

I understand that my records are protected by applicable federal and state laws/regulations and cannot be released without my written consent unless otherwise provided for by law. *See* 42 CFR Part 2; 42 U.S.C. §§290dd-22; Annotated Code of Maryland, *Health-General*, §§4-302, 4-306, *et seq*. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

I understand that this consent for the release of information will be in effect beginning on the date signed and will expire one year later, or earlier if the patient is discharged from CBHC, LLC.

I understand that I may revoke this consent at any time (except to the extent that action has been taken in reliance on it) by written request.

I am only authorizing the release of the information/reports as specified by my initials as indicated below:

_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment/Aftercare Plan
_____ Assessment/Evaluation Summary
_____ Neurological Evaluation
_____ Diagnosis
_____ Treatment Summary
_____ Discharge Summary
_____ Inoculation Records

_____ Bio-psychosocial
_____ Medical History/Evaluation
_____ Neuropsychological Evaluation
_____ Social Work Report
_____ Court Records
_____ Academic Records
_____ Billing Information
_____ Other: Admission date, medication, psychiatrist & clinician
_____ Most Recent Physical History / Exam

Information is to be released to / from:
Chesapeake Behavioral Health Center, LLC
217 Main Street, Suite B
Reisterstown, MD 21136-1213
Phone. (410) 833-0581 Fax (410) 833-8604

from / to: PCP, Therapist, Neurologist, prior provider
Name: _____
Address: _____
_____
Phone: ( ) _____ Fax: ( ) _____

I understand that I am consenting to release this confidential information to be used only in a professional manner by the person/organization to which this information is being forwarded.

x_____	_____	_____	_____
Client's Signature	**Date**	Witness' Signature	Date
_____	_____	_____	_____
Guardian's Signature if Required	Date	Staff Representative	Date