LiveWell Therapy Services, LLC
7520 Main Street, Suite 101
Sykesville Maryland 21784
443-842-6200

Authorization to Release Mental Health Information

I _____(patients name)

authorize LiveWell Therapy Services, LLC to Release Mental Health Records to:

_____

_____

_____

Information to be released:

Diagnosis ___

Treatment Plan & Goals

Treatment History _____

Medication/Medical data_____

Assessment/Psychosocial Evaluation ___

Impressions/Recommendations _____

Other
(specify)_____

I understand that the release is valid from the date this authorization is signed until _____. This authorization may be revoked, if done in writing, at anytime unless action has already been taken prior to receipt of written revocation. I have been informed of the type of information being released. I understand that treatment services are not contingent upon my decision concerning the signing of this release. This document is being given to you in order to help you make informed decisions about authorizing the disclosure of your clinical information to others.

Authorization to Release Mental Health Information

_____

(Client, Parent or Guardian Signature)

Date_____

DOB_____

Client's Address:

_____

_____

Telephone #_____

Therapist Signature_____

Date _____

I have accepted a copy of this form_____
Initials

I have rejected a copy of this form_____
Initials