John Dunn, MA, LCPAT, ATR-BC
Annapolis Art Therapy
1831 Forest Drive, Suite F, Annapolis, Maryland 21401
Phone: (443)603-5484

Authorization for Release of Confidential Information

Client Name:____________________________ Birth Date:__________ Home Phone #:__________________

Address:____ Cell Phone #:_____________________

I authorize John Dunn, MA, LCPAT, ATR-BC to communicate in the following ways with the provider listed below; ☐ to obtain and/or ☐ release copies of mental health information from medical records and/or ☐ to discuss mental health information for the following purpose: ______________________________________

Provider Name/Address:____

____

Phone#: ____ Fax#: ____________________________

For treatment dates: _______________________________ ☐Inpatient ☐Partial Hospitalization ☐Outpatient

Select Portions: ☐Admission Notes ❑Psychosocial History ☐Treatment History ☐Discharge Summary

This authorization will expire one year from the date signed below unless a specific expiration event or condition is named here:______________________________. The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this authorization for release of confidential health information. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form to assure treatment. I understand that I may inspect the information to be disclosed as provided by CFR 164.524.

- I, the undersigned have read the above and authorize the staff of the disclosing facility named to disclose such information as described in this document.
- I understand that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I may withdraw this authorization by notifying, in writing, the medical records department.
- I acknowledge that the material authorized for release may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.
- I understand that disclosure of health information to a party other than the one designated above is forbidden without additional authorization on my part.
- I understand that health information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2.
- This treatment provider/facility is released and discharged of any liability and the undersigned will hold the treatment provider/facility harmless for complying with this “Authorization for the Release of Confidential Information”.

Signature of Client:____ Date:_____________________

Signature of Parent/Guardian:____________________________________ Date:_____________________

Relationship to Client:____

Treatment Provider: This information has been disclosed to you from records protected by federal confidentiality rules 42 CFR Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any patient for alcohol or drug abuse related concerns.