



# You Are Worth It Counseling Services, LLC.

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## AUTHORIZATION TO RELEASE INFORMATION

I authorize YOU ARE WORTH IT COUNSELING SERVICES to release to, and receive from (Select one, fill out additional forms if necessary)

<input type="checkbox"/> Insurance Company	<input type="checkbox"/> Hospital	<input type="checkbox"/> Primary Care Physician [ ]
<input type="checkbox"/> Pediatrician	<input type="checkbox"/> Court System	<input type="checkbox"/> School System
<input type="checkbox"/> Family Member/Support person		<input type="checkbox"/> Other _____

(Release To Name): \_\_\_\_\_

(Release To Address) : \_\_\_\_\_

(Release To Phone Number): \_\_\_\_\_

(Patient name)	(DOB)
<input type="checkbox"/> Medical Records	<input type="checkbox"/> Academic Records/Educational Evaluation
<input type="checkbox"/> Clinical Records	<input type="checkbox"/> Treatment Plan/Patient Progress
<input type="checkbox"/> Neurological Evaluation	<input type="checkbox"/> Special Education File
<input type="checkbox"/> Results of Drug and Alcohol treatment/testing	<input type="checkbox"/> Immunization Records
	<input type="checkbox"/> Other (Specify) _____

For the purpose of: \_\_\_\_\_

This Release Expires On (one year from current Date): \_\_\_\_\_

I have been informed of the type of information being released. the benefits and disadvantages ( if any ), and understand that treatment services are not contingent upon my decision concerning the signing of this release. I have also been informed that my photocopied signature is as valid as the original.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(If patient is a minor)

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Note: Remember to ask for permission to release information to any key person who has worked with the patient and family ( i.e. probation officer, hospital clinician, private practice clinician. teacher, guidance counselor, attorney. etc. )

As required by Section 2.32(a) PROHIBITION ON DISCLOSURE –rule: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations ( 42 CFR Part 2 ) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose."