SUBURBAN CROSSROADS COUNSELING

3570 St. John's Lane, Ste 207
Ellicott City, MD 21228
410-719-0086
http://www.baltimorecounselingservices.org/

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize the Counseling Center to:

- [✔] release to:
- [✔] obtain from:
- [✔] exchange with:

_____
_____
_____
_____

the following information pertaining to myself:

- [✔] treatment summary
- [✔] history/intake
- [✔] diagnosis
- [✔] psychological test results
- [✔] psychiatric evaluation/medication history
- [✔] dates of treatment attendance
- [ ] other (specify) _____

for the purpose of:

- [✔] evaluation/assessment and/or coordinating treatment efforts
- [ ] other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____ _____. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Social Security #:_____
Signature of Client Date OR
Date of Birth:_____

7/12/2021
_____
Signature of Witness Date