



AUTHORIZATION FOR RELEASE OF INFORMATION

While sessions are confidential, signing this form allows your clinician to collaborate with anyone who may prove helpful to your treatment including but not limited to a loved one, medical doctors, referring agencies, etc.

I hereby give my informed consent to Clear View Counseling Center, LLC to:

- Disclose information to:

- Obtain information from:

- Exchange information with:

Clear View Counseling Center, LLC
1819 Bay Ridge Ave., STE 190
Annapolis, MD 21403
(443) 281-9430

Regarding copies of and/or discussions related to reports designated below for continuing treatment.

- | | |
|---|---|
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Termination/ Discharge Summary |
| <input type="checkbox"/> Admission Assessment | <input type="checkbox"/> Social Services Progress Notes |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Medical Information |
| <input type="checkbox"/> Psychologist Progress Notes | <input type="checkbox"/> Dependent's Treatment/ Care |
| <input type="checkbox"/> Updated Primary Care Referral | <input type="checkbox"/> Updated Care Referral |
| <input type="checkbox"/> Outpatient Treatment Report | <input type="checkbox"/> Other (Specify): _____ |
| <input type="checkbox"/> Pertinent Court/ Legal Documents | |

Purpose of disclosure:

- | | |
|---|--|
| <input type="checkbox"/> Assessment & Treatment | <input type="checkbox"/> Forensic/ Attorney Consultation |
| <input type="checkbox"/> Discharge Planning | <input type="checkbox"/> Other: _____ |

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____

