Second Chance Counseling Services
15713 Crabbs Branch Way, Ste 250
Rockville, Maryland 20855
TELEPHONE: (240) 751.2034 FAX: (301) 560-3454

AUTHORIZATION FOR THE RELEASE / EXCHANGE OF MEDICAL INFORMATION

Patient Name:	Date of Birth:	Social Security Number:
Street Address:	City:	State/Zip:

I authorize Second Chance Counseling Services (attention:_____) to (please check)

____Exchange with ___ Release to _____Obtain from the party I have indicated below:

Name:
Relationship:
Address:
City/State/Zip:
Phone Number:

I authorize the release/exchange of the following medical information (check all applicable):

___All materials in records ____Termination/discharge note

___Oral discussion of any information relating ____Summary of psychological testing

I understand that I may revoke this authorization at any time, unless action has already been taken on it by giving written notice to the parties below; This authorization automatically expires one year from the date I sign it. The re-release of this information to parties other than those named above is prohibited except as otherwise provided by law.

___Intake note ___Treatment plans ____Progress notes ___Other:_____

_____ _____

Signature of PatientlParentlLegal Guardian Date Relationship to Patient (if applicable)

_____

Therapist Signature