Phone (410) 780-5203

☐ **1114 Benfield Blvd Suite G**
Millersville, MD 21108
Fax (410) 987-4301

☐ **9627 Philadelphia Rd #160**
Rosedale, MD 21237
Fax (410) 780-5205

☐ **12501 Prosperity Dr Suite 235**
Silver Spring, MD 20904
Fax (240) 641-8042

☐ **5720 Executive Dr #102**
Catonsville, MD 21228
Fax (410) 747-7000

Client Name: _____ Date of Birth: _____

Consent for Release of Information—General

☐ **Not Applicable**

Authorization and Consent for Release of Information

WHO

By signing below, I authorize **Thrive Behavioral Health** and staff members to release and receive written and or/verbal information related to the client listed above to the person or agency indicated below:

To and From: _____ Phone: _____ Fax: _____
Address (if available): _____ Dates of Service: Any and all, unless indicated here: _____

WHAT

I specifically authorize the exchange of the following information:
__ Medical Records
__ School and educational records
__ Verbal discussion of case (including, but not limited to diagnosis, attendance, treatment progress, interventions, psychosocial history, and recommendations).
__ Mental Health Records including Evaluations, Individualized Treatment Plans, and Medication History
__ Information related to and/or including substance use, substance abuse history, assessment, treatment, progress and referrals
__ Information related to and/or including HIV, AIDS, or other STD related information
__Other: _____

WHY

__ Continuity of Care/Treatment coordination __Client or Parent/Legal Guardian's request __ Legal purposes
__Other: _____

Important Information

I understand that:

- This authorization is voluntary. My treatment will not be impacted if I do not sign this authorization. I do understand that Thrive psychiatrists or nurse practitioners are not required to prescribe medication if they determine they do not have enough information in order to make an informed medical decision.
- This authorization is valid 1 year from date signed unless otherwise indicated and specified here:_____.
- I may revoke/withdraw this authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by notifying Thrive in writing of withdrawal of authorization to release information.
- Once my health information is exchanged/released, it may no longer be protected by federal law and could be redisclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature

Client/Legal Guardian: _____ Date: _____
Relationship to Client: ___ self ___Other: _____ (must have legal guardianship to authorize release of information)

Updated: 10/24/19