Karoll Counseling, LLC
744 Dulaney Valley Road, Suite 8B, Towson, MD 21204
Phone 443-535-3130 / Fax 410-630-3744

Authorization Form

I authorize Karoll Counseling, LLC to release________ and /or obtain _______ the following information
Initial Initial

concerning myself ______________________________ or my child ______________________________.
Name Child's Name

_____Diagnosis, Prognosis, Recommendations
_____Psychological Evaluations
_____Psychiatric Evaluation Report
_____Report of Teachers Observations
_____Other:___________________________

_____Academic Records
_____Hospital Records
_____Medical Records
_____Treatment records

This information should only be released to and / or obtained from

Name: ____

Address: ____

____

Phone(s): ____

Email: _________________________________ FAX: _________________________________

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Unless sooner revoked, this authorization expires on the following date: ________________ or as otherwise indicated:____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Carolyn Karoll, LCSW-C, CEDS-S, at her office address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. I understand that Karoll Counseling, LLC, may not condition treatment upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

Unless specifically requested in writing that the disclosure be made in a certain format, Karoll Counseling, LLC, reserves the right to disclose information as permitted by this authorization in any manner deemed to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

____ __________________
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual.