Karoll Counseling, LLC
744 Dulaney Valley Road, Suite 8B
Towson, Maryland 21204
phone: 443.535.3130
fax: 410.630.3744

Authorization to Disclose/Obtain Protected Information

Patient's Name: _____
First Middle Last

Date of Birth: _____

This release authorizes Carolyn Karoll LCSW-C to disclose to/obtain 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.

Information to be released: _____

_____

Form of Disclosure: Unless you have 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 that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I hereby request and authorize the release of information as specified above. I understand that the confidentiality of my records is protected by Federal and State Law and cannot be released or disclosed without my written permission unless otherwise provided for in the law. I understand that by law I need not consent to the release of this information; however, I choose to do so willingly and voluntarily for the purpose specified above. I understand that I may revoke this consent/authorization at any time except to the extent that action has been taken in reliance on my consent. Unless sooner revoked or fulfilled, this consent with automatically expire one month after the termination of treatment with Carolyn Karoll LCSW-C.

_____ _____
Signature of Patient Date Signature of Witness Date

_____
Signature of Parent/Guardian if Minor Date