Rebecca Tillemans, MS LCPC
10801 Hickory Ridge Road, Suite 220
Columbia, MD 21044
+1 410 456 3549

AUTHORIZATION TO RELEASE INFORMATION

Patient name: _____Date of Birth_____

Address: _____

_____

I, _____ authorize **Rebecca Tillemans, MS LCPC** to release/exchange confidential information contained in my/my child's clinical records with:

Name_____

Address_____

_____

Phone_____FAX_____

I understand I have no obligation to disclose the requested information, and that I may revoke this consent at any time by informing the above individuals in writing. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of information. Re-disclosure to a third party of any confidential information is prohibited without my specific written authorization. Type of information to be disclosed (circle all that apply):

Clinical Assessment	Drug/Alcohol History	Recommendations
Treatment Summary	Progress in Treatment	Admissions Summary
Psychiatric Evaluation	Psychological Testing	Discharge Summary

Other: _____

The purpose of such disclosure/exchange is:

Continuity of treatment	Aftercare Planning	Referral

Other:_____

_____ _____

Patient Signature Date

_____ _____

Patient Representative/Parent Date