FIRST CHOICE COUNSELING CENTER
OUTPATIENT MENTAL HEALTH
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Full Name: Parent/Guardian Name:	Date of Birth:
Full Home Address:	Phone Number:

Authorizes Disclosures To and From:
First Choice Counseling Center
17 Warren Rd Ste 1-A Pikesville, MD 21208
(410) 929 4793 (Office) | (410) 779 9400 (Fax)
TO RELEASE MEDICAL INFORMATION TO AND FROM:

Name (Healthcare Provider, Organization etc.):	Phone Number:
Full Address:	Fax Number:

PURPOSE OF THIS DISCLOSURE (Choose all that Apply)		
□Treatment/Continuing Care □ Personal Use □ Billing or Claims	□ Insurance □ Legal Purposes □ Disability Determination	□ School □ Employment □ Other*(Specify)*: _____
INFORMATION TO BE DISCLOSED:		
□ Medical Record from (insert date) _____ to (insert date) _____ □ Entire Medical Record		
I AUTHORIZE THE FOLLOWING TO BE RELEASED:		
□ Progress Notes □ Assessments □ Discharge Summary	□ Treatment Plan □ Office Visit Notes □ Other: _____	□ Specific information related to: _____
FORMAT OF INFORMATION TO BE DISCLOSED: □Paper □ Email (pdf format)_____ □Address: _____ By signing below you acknowledge that the security of transmission is not guaranteed.		

YOUR RIGHTS REGARDING THIS AUTHORIZATION Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact FCCC I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. FCCC will not condition treatment on the completion of this authorization.

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

EXPIRATION DATE: This authorization is effective for one (1) year from the date signed unless otherwise indicated. _____Date (Optional)

_____ _____ _____
Patient or Legal Representative Signature Relationship Date of Signature

My signature below specifically authorizes the release of health information relating to testing, diagnosis and treatment for:

□ AIDS/HIV/STDs □ Alcohol/Drug Use □ Developmental Disabilities

_____ _____ _____
Patient or Legal Representative Signature Relationship Date of Signature