Request for Record from (Therapist Name).

Re: _____Date of birth: _____

I give permission for, and request, the release of the records of my treatment

with_____ (therapist name here)

Approximate dates (month/year) when I was in treatment here _____

I request: (check one) ____Summary of Treatment ____Complete Record

I request that the records be provided to:

_____Myself. In this case, please provide your current mailing and email addresses:

_____

_____

____Another individual or organization.

Please provide the name, mailing address, email address and fax number of the individual or organization you would like the records sent to:

I understand that if the person or agency that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by those regulations.

Limitations or exclusions of information to be disclosed:

(Specify_____

_____)

This authorization expires six months after the date signed, unless otherwise noted, and I have the right to revoke this authorization at any time either in writing or verbally.. If requested by my therapist in the interest of protecting my privacy, upon request I will provide additional documentation to verify my identity.

This form may be sent by email to: info@sugarloafcounseling.com, mailed to 18 Executive Park Court, Germantown, MD, or faxed to 301-972-6635.

Signature_____Date_____

(If parent or guardian, state relationship) _____