AMERICAN
PSYCHIATRIC GROUP

Comprehensive Consent for Release of Information

Client Name: _____ Date of Birth: _____

I/We hereby authorize American Psychiatric Group to _____ send to _____ receive from:

Please Print Agency Name, Contact, Address, Phone and fax below:

_____

_____

_____

□ Psychiatric Evaluation and Treatment History □ Aftercare Plan □ Physician's Progress Notes

□ Social History □ Legal Documentation (court order, etc.) □ Discharge Summary

□ Substance Abuse History and Treatment □ Medication Record □ Signed SMI Certification

□ Physical Exam and Medical History □ Current Labs □ Guardianship Documentation

□ Fact or Face Sheet □ Psychological Evaluation

□ Academic and educational records □ Other (please specify): _____

(report cards, attendance, IEP reports, etc) including achievement testing

I authorize American Psychiatric Group to speak with you about the reason for referral, any relevant history, or diagnoses and to share other information to assist with the client's treatment and/or evaluation.

This authorization to release information is being made to aid in planning effective evaluation and treatment for this client. I understand that no services will be denied solely because I refuse to consent to this release of information, and that I am not obligated to release them. I do release them because I believe they are necessary to assist in the development of the best possible treatment plan for the client.

In consideration of this consent, I hereby release the above source of records from any and all liability arising there from. I understand that the information disclosed pursuant to the written authorization may be re-disclosed by the recipient and is no longer protected by the federal privacy regulations. I understand that I may void this authorization, except for action already taken, at any time by means of a written letter revoking the authorization, but that this revocation is not retroactive. Unless expressly revoked earlier, this consent expires upon completion of the current treatment and/or one year from the current date.

Signature of Client _____ Date: _____

Signature of Custodial Parent or Guardian _____ Date: _____

Signature of Witness _____ Date: _____

17 E. Franklin Street Baltimore, MD 21202 P: 410-600-3500 F: 410-600-3499