AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: ________________________________ Age: ______ Date of Birth: ____________________

Provide one: **a)** Social Security Number: ______–______–_______ **b)** ID State: ______ #: ____________

I hereby authorize: Gerard Grigsby, PhD, LCPC, LPC
Grigsby Counseling Services, LLC
Mount Rainier, MD 20712
Ph: 240-623-0496 Fax: 240-241-6417

(Please check only one option below)

☐ **To obtain information from:** ☐ **To release information to:** ☐ **To exchange information with:**

Person: ____
Agency: ____
Address: ____
____
Phone: ______________________________ Fax: ______________________________

The following information: *(check all that apply)*

☐ Verification of Attendance ☐ Medication Information ☐ Psychiatric Treatment
☐ Assessment and Diagnosis ☐ Summary of Treatment ☐ Alcohol/Other Drug records

☐ Other: ____

The purpose of disclosure is: *(check all that apply)*

☐ Communication with Third Party ☐ Continuity of Care
☐ Coordination of Services ☐ Assisting in Assessment

☐ Other: ____

This authorization shall remain in effect for: *(check only one. "Other" may be a date, or an event [e.g., termination])*

☐ Thirty (30) days ☐ Sixty (60) days ☐ Ninety (90) days ☐ Other __________________

Please note: The information used or disclosed as a result of this authorization could potentially be re-disclosed by the recipient of your information and no longer protected by HIPAA Privacy Rules.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Gerard Grigsby at 100 Owings Court, Suite 12, Reisterstown, MD 21136. However, your revocation will not be effective to the extent that I have already taken action in reliance on the authorization.

____ ____________________________
Client Name *(print)* Witness Signature

____ ______________
Client Signature Date