nurturing baltimore moms

sara daly
LCSW-C

Authorization to Release
Mental Health Treatment Information

I, _____ (DOB=_____),
authorize Sara Daly, LCSW-C, of Nurturing Baltimore Moms, to disclose to and/or obtain from:

_____
the following information, as indicated by my initials and signature at the end of this document.

Description of Information to be Disclosed:

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ Attendance to Treatment
_____ Current Treatment Update
_____ Discharge/Transfer Summary
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Sara Daly, LCSW-C at the address below. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____.

Conditions

I further understand that Nurturing Baltimore Moms will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Staff Witness Date

☐ Check here if patient/client refuses to sign authorization

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