# RELEASE OF INFORMATION AUTHORIZATION

BASICS COUNSELING & TESTING
A DIVISION OF BASICS GROUP PRACTICE, LLC

BASICS GROUP PRACTICE LLC.
301.420.1972 | info@basicscounseling.com
7610 Pennsylvania Avenue, Suite 203
Forestville, MD 20747

| Client Name | Complete Address | DOB | Phone |
|---|---|---|---|
| | | | |

1. BASICS Group Practice LLC and all its authorized representatives have my permission to:

☐ send ☐ receive ☐ verbally discuss the information checked below with:
Agency/Individual: _____
Address: _____
_____

2. *Initial all items covered by this release.*

_____ Acknowledgment of receipt of services
_____ Complete program record (includes all items below)
_____ Intake Assessment _____ Treatment Plan _____ Progress Notes _____ Diagnosis
_____ Psychological Evaluation
_____ Other (specify)
_____

3. Reason for Request:

4.This authorization is valid (*Check only one-not to exceed one year*)

☐ until_____(date) ☐ for 365 days ☐ until these conditions are met: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Furthermore, I understand that this information has been disclosed from records protected by federal law (42 C.F.R. Part 2). These records are prohibited from further disclosure without written patient consent unless otherwise mandated by law. Only such records and/or information believed necessary for the purpose expressed above shall be released. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this request, I must do so in writing and present my written revocation to BASICS Grou Practice. I understand that the revocation will not apply to information that has already been released in response to this request.

If I fail to specify an expiration date or event, this authorization will expire one year from the date it was signed and is only valid for information preceding this date. I understand that I may receive a copy of this form after I sign it and inspect and copy information to be used or disclosed. I also understand there may be a charge for this information.
I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure treatment.

_____ _____
Signature of client Date

_____ _____
Signature of parent, guardian, or other authorized person Date

If signed by other authorized person, please describe authority to act on behalf of the client and provide documentation (*Please Print )*

_____
_____
_____