# RELEASE OF INFORMATION

**CLIENT NAME: ________________________________DATE OF BIRTH: _________________**

I authorize **SHARON J. LAWRENCE, LCSW-C (SELAH WELLNESS & THERAPEUTIC SERVICES, LLC)** to disclose to and/or obtain from:

_____________________________________________________ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

_____ Diagnosis
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ Discharge/Transfer Summary
______Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
______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.
_____________________________________________________________________________
_____________________________________________________________________________

Expiration

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

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 that is disclosed pursuant to this authorization may be redisclosed 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 Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

______________________________________________________________________
Signature of Staff Witness Date

Sharon J. Lawrence,LCSW-C, LCSW, ACSW, EAS-C, CAMS-II, DCC
(301) 875-5680
9500 Medical Center Drive, Suite 440-E, Largo, MD 20774
sharonlawrence@myselahwellness.com