Woods Counseling and Therapy Services of Maryland
9672 Pennsylvania Ave
Upper Marlboro, MD 20772
(301) 599-7905

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

I, _____authorize Woods Counseling and Therapy Services (herein as "practice") to release confidential health care information to the following party(ies) pertaining to _____:

1._____
2._____
3._____

I understand that I have the right to revoke this authorization at any time, but only in writing. I also understand that this release form expires exactly one year from the date of signature (see below). I authorize this practice to release medical and mental health treatment, history, diagnostics and any associated testing to the above written party(ies). You have the right to refuse to sign this document, while understanding that such a choice may hinder continuity of care. I also understand that the party(ies) receiving the protected information may not honor its confidentiality (unless the provider is bound by law (HIPAA Act, Federal) to do so, such as other licensed medical or mental health personnel).

Please write any inclusions or exclusions to this release of protected information form: _____
_____
_____

_____
Client

_____
Client's parent(s) and/or legal guardian(s)

_____
Date of Signature

_____
Witness

_____
Daniel M. Woods, LCPC, CCFC
Director, Primary Therapist