



The Baltimore Therapy Center, LLC
103 Old Court Rd., Suite A
Baltimore, MD 21215
443-598-BTC1 (2821)

Authorization for Release of Confidential Information

I, _____, (date of birth: _____) hereby authorize the following people to disclose information about my medical records to Baltimore Therapy Center staff, for the purpose of facilitating treatment (*please include name and phone number*):

and for the Baltimore Therapy Center to disclose:

- all information relevant to my case.
- only that I am in treatment.
- only the following information:

This authorization shall be voided at the termination of therapy, or at any such time as I choose to revoke it in writing.

Name of client: _____

Date: _____

Signature: _____