The Baltimore Therapy Center, LLC
103 Old Court Rd., Suite A
Baltimore, MD 21208
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 the Baltimore Therapy Center staff, for the purpose of facilitating treatment:

Name of Individual/Agency: _____

Contact Information: _____

and for the Baltimore Therapy Center to disclose:

☐ all information relevant to my case.

☐ only that I am in treatment.

☐ only the following information:

_____

_____

_____

_____

I understand that I am not required to sign this authorization and that I will not be subject to any penalty for failing to sign it. 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: _____