

RENAISSANCE CENTER
6665 SECURITY BLVD. WOODLAWN, MD 21207
410-265-7291 PHONE 410265-7294 FAX
AUTHORIZATION TO RELEASE INFORMATION

Staff Requesting Information: _____ Date: _____

I _____, hereby consent to and
Print Name

authorize MSBC to disclose and/or receive the following information:

- | | |
|---|---|
| <input type="checkbox"/> Diagnosis/ Assessment | <input type="checkbox"/> Results of Drug Screen/testing |
| <input type="checkbox"/> Treatment/ Rehabilitation | <input type="checkbox"/> Attendance & Fee Payment History |
| <input type="checkbox"/> Medication/ Prescriptions | <input type="checkbox"/> Education/ Vocational Assessment |
| <input type="checkbox"/> Latest Physical Examination | <input type="checkbox"/> Psychological Assessment |
| <input type="checkbox"/> Immunization Record/ Allergies | <input type="checkbox"/> Pastor Debnam |
| <input type="checkbox"/> Record of Treatment from your facility | <input type="checkbox"/> All of the Above |
| <input type="checkbox"/> Discharge Summary | |

From _____

Fax: _____ **Phone#** _____

Client's Signature Date

Social Security Date of Birth

Guardian (if applicable): _____
Print Name Date

Signature: _____ Relationship to Client: _____

I understand that my records are protected under the Federal Confidentiality Regulations (42 CFR) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance on it. This consent expires one year from the above date or upon my termination of service from MSBC.

Client or guardians initials: _____