Mary E. Tessman, MA, LCPC
Wellspring Healing Arts
1300 York Road Suite 240-B
Lutherville, MD 21093
410-370-6764

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

PATIENT'S NAME _____

I authorize, Mary E. Tessman, MA, LCPC and Wellspring Healing Arts, 1300 York Road Suite 240-B Lutherville, MD 21093, and/or _____,
to disclose information and records regarding my treatment, medical and/or behavioral health condition to the following professional person/agency, physician and/or facility;

_____.
Name, Address, City State ZIP

Information to be released or exchanged include (check all that apply):
_____ History and physical
_____ Discharge and Summary
_____ Behavioral Health Treatment Records
_____ Other (specify) _____
The authorized purpose(s) for this release are:
_____ Diagnosis and Treatment
_____ Coordination of Care
_____ Payment Purposes
_____ Other (specify) _____

I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. I may revoke this authorization. This authorization is valid until I revoke it or 60 days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

This authorization was explained to me as I signed it of my own free will on:

The _____day of _____, 20____.

_____ Signature of Client/Patient

_____ Signature of Witness