Consent for Release of Information to
Caring Hearts Mental Health Services, LLC
Mary Ann Dameron, PMHNP

365 W. Patrick St. Suite 205
Frederick, MD 21701
maryanndameron@caringheartsmhs.com
Phone: 240-446-0717 Fax: 410-202-2107

I, ____ Date of Birth_____________________________________
(Full name of client)

Hereby authorize the exchange of information between:

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And
Mary Ann Dameron, PMHNP owner as well as staff of Caring Hearts Mental Health Services, LLC.

This may include: All records, evaluations, results, and verbal conversations and any other pertinent data.

The records are required for the specific purpose of continuity of care, continuation of care, collaboration of care and/or transfer of care.

I understand that my authorization shall remain effective for a period of two years from the date of my signature and that all information released will be handled confidentially, in compliance with Federal Privacy Act P.L. 93-575, the Federal Alcohol and Drug Abuse Act P.L. 92-282 and the Maryland Mental Health Code HG 8-601.
I also understand that I may revoke this authorization (except to the extent that action has already been taken in reliance thereon) at any time by written communication to Mary Ann Dameron, PMHNP, Owner, as well as staff of Caring Hearts Mental Health Services, LLC.
It is agreed that the recipient of this information will refrain from and will protect against disclosure of any information received which is not authorized by further consent against disclosure of any information received which is not authorized by further consent of the patient, of his/her guardian, guardian or authorized representative unless provided for under law or regulation.
I understand that I will not be required to sign this authorization as a condition of my ability to obtain treatment or payment or my eligibility for benefits.

____ _______________________________________
Patient Signature Parent or Legal Guardian

Date____