Consent for Release of Information

Caring Hearts Mental Health Services, LLC

Mary Ann Dameron, CRNP, PMHNP

Ph. 240-446-0717 – MaryAnnDameron@caringheartsmhs.com

INFORMED CONSENT FOR THERAPY/MEDICATION MANAGEMENT SERVICES

I, ____ Date of Birth _______________________________

(Client Name)

Hereby authorize the exchange of information between:

____

Full name of person or provider you wish us to contact or exchange information with or get information from

____

Their address, phone number, email and fax number

And Mary Ann Dameron CRNP, PMHNP owner as well as staff of Caring Hearts Mental Health Services, LLC. This may include records, reports, verbal conversations and all records or other data to be released.

Specific Records, if any:

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

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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 the 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 S8-601)

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 and dated communication to Mary Ann Dameron CRNP, PMHNP – Owner, as well as staff and providers at 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 of the patient or his/her parent/guardian or authorized representative, unless provided for under law or regulation.

I understand that I may not be required to sign this authorization as a condition of my ability to obtain treatment or payment or my eligibility for benefits.

____	____
Client Signature	**Parent or Legal Guardian**
____	____
Witness	**Date**