OLNEY
Counseling Center, LLC
Providing help and hope for those in need.

3300 Olney Sandy Spring Rd, Suite 340
Olney, MD 20832

office@OlneyCounseling.com
(301)570-7500 Fax (301)570-7504

Multi-Party Authorization & Consent Form

* Consent for Release and Exchange of Confidential Information

I, _____, authorize the following information to be disclosed and exchanged as necessary to evaluate my need for services and to coordinate those services being provided to me.

Patient Name:_____ DOB: _____

Clinician: _____of Olney Counseling Center LLC

The purpose or need for the exchange and disclosure of this information is to: (check all that apply)

- ☐ Facilitate Treatment
- ☐ All Healthcare Information
- ☐ Summarize Treatment
- ☐ Medical Records
- ☐ Coordinate Continuing Care
- ☐ Other (please state purpose clearly)_____
- ☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment for the patient named.

To: (Check one)

- ☐ Mental Health Care provider _____of Olney Counseling Center LLC.

  or

- ☐ Name: _____ of _____

  Address: _____

  Phone: _____ Fax: _____

  Email:_____

I understand that my treatment records are protected under Federal HIPAA Laws and cannot be disclosed without my written consent unless otherwise provided for by 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, and that in any event this consent expires automatically one year from the date of signature or ending services with the provider, whichever is sooner.

I have read this authorization and I understand it fully, and voluntarily sign:

_____

Client, Parent, or Managing Conservator Date