Phone: (667) 668-2566
Fax: (240) 317-7626

120 Sister Pierre Drive, Suite 403, Towson, MD 21204
4520 East West Highway, Suite 775, Bethesda, MD 20814
7001 Johnnycake Road, Suite 107, Windsor Mill, MD 21244
604 S. Frederick Avenue, Suite 211, Gaithersburg, MD 20877
9520 Berger Road, Suite 203, Columbia, MD 21046
1831 Forest Drive, Suite A, Annapolis, MD 21401
921 E. Fort Avenue, Suite 100, Baltimore, MD 21230
801 N. Quincy Street, Suite 601, Arlington, VA, 22203

RELEASE OF INFORMATION FORM

I authorize **Bloom Health Centers** to release/obtain the following information noted regarding mental health records for:

Patient Name: ____ DOB: __________________________

From the treatment period of: _____________________________________ to ____

This information should be (**CHECK ONE ONLY**) ________ **RELEASED TO** ________**OBTAINED FROM**

- PCP
- Psychiatrist and/or Therapist
- Specialist (i.e. neurologist
- Hospital
- Family Member
- Employer
- School
- Legal
- Other

____

Name: ____

Phone: ____

Fax: ____

Address: ____

Email: ____

________ **Initial here to confirm BHC sending records via UNENCRYPTED EMAIL**

For the purpose of:

_____ Coordination of care
_____ Continuing care
_____ Background information
_____ Evaluation
_____ At the request of the individual

Select the specific type(s) of records to released:

_____ All medical information
_____ Evaluation/ progress reports
_____ Medications
_____ Psychological evaluation and reports
_____ Billing, scheduling, and attendance information

I understand this consent is valid for 12 months from the date signed, unless otherwise revoked in writing. As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

Signature: ____ Date: _________________________

Printed Name/ Legal Guardian: ____