IMARA
COUNSELING SERVICES

Authorization to use and Disclose Protected Health Information

I, the Undersigned, authorize Imara Counseling Services, to allow the use and sharing of protected health information about:

Client Name: _____

Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

With the following individual/entity:

Name/Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

Once completed and signed, this authorization will remain in effect for one (1) calendar year until _____/_____/_____ per COMAR regulations

The mental health information authorized for release includes:

☐ Discharge Summaries ☐ Consultations ☐ Records/Case Notes

☐ Psychological Assessments ☐ Psychiatric Evaluations ☐ Other: _____

Disclosure: I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Office of the Organization listed above and which is to supply this information. If I do this I will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I do not have to sign this authorization and that my refusal will not affect my abilities to obtain treatment from the professional or facility listed above, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this authorization.

_____ _____/_____/_____

Client/Parent/Guardian Signature **Date**

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