Diana Mayer, LCMFT
4405 East-West Highway
Bethesda, Maryland 20814
(202) 670- 0427
LCM488

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ DOB: _____
Address: _____

Exchange of information with (Name / Agency): _____
Address: _____ Phone: _____ Fax: _____

I, _____, freely give consent to Diana Mayer, LCMFT and the informant to
Client Name or Legal Guardian
exchange the below noted information for the purpose of payment, facilitating treatment, and continuity of care for me or for my child.

Notification of beginning / ending of treatment	☐	Periodic summary of treatment progress	☐
Past treatment	☐	Intake assessment summary	☐
Psychological evaluation	☐	Financial information	☐
Discharge summary	☐	Current psychiatric diagnosis	☐
Service agreement and treatment planning	☐	Verbal exchange of information	☐
List of current psychotropic medication	☐	Other _____	☐

This consent to release information is given freely, voluntarily, and without coercion, and may be withdrawn by me at any time. Any information I authorize other professionals to release to Diana Mayer will be held strictly confidential and will not be released without my written permission except as permitted by the State or Federal law. I understand that I have the right to inspect the record or mental health information on the above-named individual.
This Authorization is effective for one year from the date below.

_____	_____	_____
Date	Signature of client / Guardian	Please print your name

Relationship to client: ☐ Self ☐ Legal guardian ☐ Foster parent ☐ Social worker ☐ Other: _____

_____	_____
Signature of Witness	Date

I agree that the information above has not changed since the last date it was signed.

_____	_____	_____
Client / Guardian signature	Print Name	Date
_____	_____	_____
Client / Guardian signature	Print Name	Date
_____	_____	_____
Client / Guardian signature	Print Name	Date

Date Revoked ____ / ____ / _____ Reason: _____