

# HYGEIA COUNSELING SERVICES

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (All clients)

For this authorization, "My Health Information" is:

- Complete Record (all)       Abstract Record (discharge summary, recent notes, test results)  
 Discharge Summary       All Mental Health Records       Drug & Alcohol Treatment Record  
 Emergency Room Record       Diagnostic Test/Results (lab, x-rays, and other test results)  
 Free give and take discussion       All Somatic Health Records       All Psychological Testing Records

Other: \_\_\_\_\_

I authorize \_\_\_\_\_ to disclose My Health Information to Michael Reeder / Hygeia Counseling Services for the purposes of:

Coordination of ongoing treatment

Other: \_\_\_\_\_

I authorize James Michael Reeder (DBA "Hygeia Counseling Services") to disclose My Health

Information to \_\_\_\_\_ for the purposes of:

Coordination of ongoing treatment

Other: \_\_\_\_\_

**Health Information being sent to James Michael Reeder (DBA "Hygeia Counseling Services") should be faxed to 443-524-9610 or mailed to Hygeia Counseling Services, 6400 Baltimore National Pike #205, Catonsville, MD 21228.**

I understand there may be a charge for copying and handling my request. I understand all fees would be in compliance with legal guidelines. By signing this authorization, I agree to pay such fees if requested. This authorization is valid for one (1) year from date of signature, or until revoked in writing.

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ SSN#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_