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

___ 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:

_**X**_ Coordination of ongoing treatment.

___ Other:_____

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

Information to _____for the purposes of:

_**X**_ **Episodic** coordination of ongoing treatment. (I hereby deny permission for automatic written reports being sent to this party and myself after each individual counseling episode.)

___ 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:_____

Version 12/27/20