LISA K. SCHKLOVEN, LCSW-C

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PIKESVILLE, MD 21208
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RELEASE OF PROFESSIONAL INFORMATION

I, _____, (DOB: ____/____/_____) authorize:

_____ Lisa K. Schkloven, LCSW-C to release my protected health information the individual/organization listed below.
INITIAL

_____ the individual/organization listed below to release my protected health information to Lisa K. Schkloven, LCSW-C.
INITIAL

Individual/Organization: _____

Address/City/State/Zip: _____

Phone: _____ FAX:_____

Information Authorized for Release in _____ Written and/or by _____ Verbal Format **ONLY**: _____ (INITIAL)

_____ Assessment and History	_____ Diagnosis	_____ Treatment Plans
_____ Medical Information	_____ Psychiatric Information	_____ Educational Information
_____ Alcohol/Substance Abuse Information	_____ Family History/Information	_____ Hospital Records/Information
_____ Medical Discharge Summaries	_____ Psychiatric Discharge Summaries	_____ Other (specify)

_____

This information will be used/ disclosed for the following purposes:
(Describe purposes for this use/disclosure of the protected health information or indicate "at the request of the individual".)

_____

_____

PLEASE READ EACH OF THE FOLLOWIG STATEMENTS CAREFULLY BEFORE SIGNING THIS DOCUMENT

1. I understand that this authorization will expire one year from the date signed unless a shorter time frame is request or a specified event has occurred.

   Date to expire (cannot exceed one year from date signed: _____

   After specified event has occurred: _____

2. I understand that this authorization is voluntary and being made at my request.

3. I understand that the released information may no longer be protected by federal privacy laws and may be re-disclosed by the individual or organization that receives it unless this information is protected under Federal confidentiality rules 42 CFR Part 2.

4. I understand that I may refuse to sign this authorization.

5. I understand that I may revoke this authorization at any time by sending a written notification to Lisa K. Schkloven, LCSW-C at the address listed at the top of this form. Once received, this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that has already been used and/or disclosed, relying on this authorization. .

6. I understand that use and/or disclosure or protected health information to a party other than the one designated above is forbidden without additional written authorization on my part.

7. Lisa K. Schkloven, LCSWC is released and discharged of any liability and I will hold her harmless for complying with this Release of Professional Information.

8. By signing this form I revoke any previous *Release of Professional Information* form signed by me at an earlier date.

Signature: _____ **Date:** _____