CONSENT FOR RELEASE OF INFORMATION

ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC
CB Benway CRNP, PMH, Owner
13327 Wisdom Way
Hagerstown, Maryland 21742
appsmentalhealth@gmail.com
Telephone: 240-970-7300 Fax: 240-231-9755

I, ______________________________________ Date of Birth____________________________
(Clients Name) (Date of Birth)

hereby authorize the exchange of information between:

____
(Full name of person or provider you wish us to contact or exchange information with or get information from)

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(Their address, phone fax, and email if you have it)

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and CB Benway CRNP, PMH, owner as well as staff and providers of ADVANCED PRACTICE PSYCHIATRIC SOLUTIONS, LLC. This may include: (Specify records, reports, verbal conversations, all records or other data to be released).

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The records are required for the specific purpose of (continuity of care, a continuation of care, collaboration of care, transfer of care, records).

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I understand that my authorization shall remain effective for a period of one year from the date of my signature and that all information released will be handled confidentially, in compliance with the Federal Privacy Act (P.L. 93-575), the Federal Alcohol and Drug Abuse Act (P.L. 92-282), and the Maryland Mental Health Code HG §8-601.

I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written dated communication to CB Benway CRNP, PMH, Owner, as well as staff and providers of & Advanced Practice Psychiatric Solutions, LLC. It is agreed that the recipient of this information will refrain from and will protect against disclosure of any information received which is not authorized by further consent of the patient of his/her parent, guardian, or authorized representative unless provided for under law or regulation.

I understand that I may not be required to sign this authorization as a condition of my ability to obtain treatment or payment or my eligibility for benefits.

______________________________ ______________________________
Clients Signature Parent or Legal Guardian

______________________________ ______________________________
Witness Date