COMPREHENSIVE CONSENT FORM

for Physician

Regarding ____ Date of Birth: ____________________

I/We hereby authorize Therapeutic Living for Families to ______ send to ______ receive from:

____

____

____

______ Medical Information, including immunization records and last physical

______ Inpatient and/or outpatient psychological/psychiatric/substance abuse treatment records

______ Academic and educational records, including achievement testing

______ Other: ___________________________________

I authorize Therapeutic Living for Families to speak by telephone with you about the reason for referral, any relevant history, or diagnoses and to share other information to assist with the client's treatment and/or evaluation.

This authorization to release medical information is being made to aid in planning effective evaluation and treatment for this client. I understand that no services will be denied solely because I refuse to consent to this release of information, and that I am not obligated to release them. I do release them because I believe they are necessary to assist in the development of the best possible treatment plan for the client.

In consideration of this consent, I hereby release the above source of records from any and all liability arising there from. I understand that I may void this authorization, except for action already taken, at any time by means of a written letter revoking the authorization, but that this revocation is not retroactive. Unless expressly revoked earlier, this consent expires upon completion of the current treatment and/or one year from current date.

Signature of Client ______________________________ Date ____________

Signature of Custodial Parent or Guardian ______________________________ Date ____________

Signature of Witness ______________________________ Date ____________

☐ At this time client does not have a primary care physician

☐ Client refuses to release primary care information

Signature of Client ______________________________ Date ____________

Signature of Custodial Parent or Guardian ______________________________ Date ____________

1837 Pulaski Highway | Edgewood, MD 21040
p 443.372.5273 | **f** 443.372.5293

3425 Sinclair Lane | Baltimore, MD 21213
p 410.366.1151 | **f** 410.366.0032

tlfmaryland.org