Please complete the form, sign and mail (with a $20 check) to:

Clary Document Management, Inc.
5600 Pioneer Creek Drive
Maple Plain, MN 55359

Phone: 763.548.1320 | Fax: 763.548.1325 | chartcontrol@clarydm.com | www.clarydm.com

AUTHORIZATION TO RELEASE MENTAL HEALTH RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____ Day Phone: _____

_____ Email: _____

I request that all records of the patient named above to be released from:

Christian Counseling Associates
9650 Santiago Road
Suite 102
Columbia, MD 21045

Year of Last Visit [ ]

Send all records to my provider below:

Name: _____

Address: _____

_____

Email: _____

Fax : _____

Reason for Release of Information:

This request and authorization applies to all my therapy records. I understand my medical records may include information regarding mental health, psychotherapy notes, alcohol/drug use, Sexually Transmitted Disease results (whether positive or negative) and HIV treatment. I understand this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when Clary Document Management (Clary) receives my notice in writing submitted to the address above. I understand once Clary discloses my health information herein, it may no longer be protected by federal privacy laws. **I understand I will pre-pay $20 to reproduce the records and reports.**

_____ Date _____
Patient Signature

_____ _____ Date _____
Patient Representative Signature Your Authority to Sign on Behalf of Patient

*STATE/COMMONWEALTH OF _____
County of _____

The foregoing instrument was acknowledged before me the _____ day of _____, 20__,

by_____

_____
Notary Public

*** Notarized signature is required**