10 W. Eager Street
Suite 324
Baltimore, MD, 21201
Phone: (443) 445-0536 Fax: (443)-753-4753

RELEASE OF INFORMATION

I understand that Breakthrough Behavioral Health Services LLC, has an obligation to keep my personal information, identifying information, and records confidential. I also understand that I can choose to allow Breakthrough Behavioral Health Services LLC, to release some of my personal information to certain individuals or agencies.

I authorize Breakthrough Behavioral Health Services LLC, to share the following specific information:

Whom I want to have my information:	Name: Specific Office at Agency: Address: Phone Number:

The information may be shared:

☐ by phone ☐by fax ☐ by mail

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What information about me may be shared:	*(List as specifically as possible. For example, name, dates of service, any documents.)*
Why I want my information shared:	*(List as specifically as possible. For example, to receive benefits.)*

I understand:

☐ That I do not have to sign a release form. I do not have to allow Breakthrough Behavioral Health Services LLC, to share my information. Signing a release form is completely voluntary.

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☐ That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Breakthrough Behavioral Health Services LLC.

☐ The risks and benefits of releasing the confidential information to the above agency or person.

☐ That a limited release of information can potentially open up access by others to all of my confidential information held by Breakthrough Behavioral Health Services LLC.

☐ That this release is limited to what I have written above. If I would like Breakthrough Behavioral Health Services LLC, to release information about me in the future, I will need to sign another written, time-limited release.

☐ That Breakthrough Behavioral Health Services LLC, and I may not be able to control what happens to my information once it has been released to another agency and that the agency or person receiving my information may be required by law or practice to share it with others.

I understand that this release is valid when I sign it, and that I may withdraw my consent to this release at any time either verbally or in writing

Patient Name: _____

Patient Signature: _____ Date & Time: _____

Witness: _____ Date & Time: _____