



# Meghan Crosby Budinger, LCPC, LLC

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## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This form when completed and signed by you, authorizes me to release protected health information from your clinical record to the person(s) whom you designate.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

I, \_\_\_\_\_, authorize Meghan Crosby Budinger, LCPC, LLC

to release the following from my record \_\_\_\_\_

\_\_\_\_\_

*Provide description of the information that you want disclosed.*

I am requesting that Meghan Crosby Budinger, LCPC, LLC release this information for the following reasons:

\_\_\_\_\_

I understand that my psychotherapist cannot re-disclose information he/she received from another health care provider if that health care provider requested that the information not be re-disclosed. This authorization shall remain in effect for a period of one year from the date below or until \_\_\_\_\_. The information is to be released to/released from:

Name: \_\_\_\_\_ Title/Position: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Meghan Crosby Budinger, LCPC, LLC. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.