PERMISSION FOR RELEASE OF INFORMATION

I, _____, hereby authorize the staff at Johns Hopkins University
(client or other authorized person completing this form)

Counseling Center (at 3003 N. Charles St., Suite S-200, Baltimore, MD 21218; phone: 410-516-8278) to:

[check one]

☒ exchange information with ☐ disclose information to ☐ receive information from

Client Name: _____ **Client Phone #:** _____
(please print)

Client Address: _____
(street) (city) (state) (zip)

DOB: __ __ / __ __ / __ __ __ __ **SS#:** x x x – x x – __ __ __ __
(month) (day) (year) (last 4 digits)

Contact Person(s) and/or Agency Name: Wellfleet Student Insurance

The information to be disclosed is:
[ ] Attendance information
[ ] Summary of treatment
[ ] All treatment records
[ ] Withdrawal/Readmission recommendation
[x] Other (specify): Referral to Community Mental Health Provider
reduction of deductible

The purpose of this disclosure is for:
[ ] Further treatment
[ ] Withdrawal/Readmission Process

[x] Other (specify): Reduction of Insurance Deductible

This consent is effective on _____ and expires on August 14, 2023_____. **I understand that I may**
(today's date) (no greater than 1 year)

revoke this consent at any time within the effective period by written request.

Client/Authorized Person Signature: _____

NOTICE*: This information has been disclosed from confidential records. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release. However, there are legal and ethical requirements that counselors take responsible action in those situations as prescribed by law 1) where there is danger of imminent harm to self or others, and 2) in the case of apparent child abuse.*