MaeWorks
PSYCHOTHERAPY SOLUTIONS
INDIVIDUALS ∞ COUPLES ∞ FAMILIES

Jason Maedl, LMFT

1501 East Avenue Suite 100 ~ Rochester NY 14610 | 585.358.0258 | www.rochestertherapy.net | jason@rochestertherapy.net

Release or Disclosure of Medical and/or Mental Health Information

This form is your authorization to allow for the release or exchange of information related to your medical and/or mental health care. The disclosure is limited to the terms stated in this form and may be revoked at any time. As described in the confidentiality section of the Informed Consent document, this form is not required in the case of an imminent harm emergency. Your right to treatment is not dependent on the completion on this form.

Your Contact Information

Full Name: _____ Date of Birth: ___/___/_____

Complete Address: _____

Best Contact Number: _____

This Authorization Allows Jason Maedl, LMFT to (Check One or Both):

_____ SEND copies of your record to (or discuss your information with) the provider/person/facility below:

_____ RECEIVE copies of your record to (or discuss your information with) the provider/person/facility below:

Name of Provider/Person/Facility: _____

Complete Address: _____

Phone Number: _____

Purpose of Request (Check All that Apply):

_____ Care Coordination _____ Billing Purposes _____ Other (Please Specify) _____

Type of Information Requested (Check All that Apply):

_____ Medical Health Information _____ Mental Health Information _____ Substance Use Information

Scope of Request:

_____ Treatment Summary _____ Specific Report or Information _____

Request is Valid for:

_____ This Request Only _____ Today Until: ___/____/_____ _____ In Perpetuity Unless Revoked

Authorization:

Signature: _____ Date: ___/___/_____