Main Phone: (667) 668-2566
Medical Records Department Phone: (410)-424-5980
Fax: (240) 317-7626

1447 York Road, Suite 601, Lutherville-Timonium, MD 21093
4520 East West Highway, Suite 775, Bethesda, MD 20814
9715 Medical Center Drive, Suite 528, Rockville, MD 20850
7001 Johnnycake Road, Suite 107, Catonsville, MD 21244
158 Front Royal Pike, Suite 206, Winchester, VA 22602
1602 Village Market Blvd SE, Suite 250, Leesburg, VA 20175
9891 Broken Land Parkway, Suite 210, Columbia, MD 21046
1750 Forest Drive, Suite 105, Annapolis, MD 21401
801 N. Quincy Street, Suite 601, Arlington, VA 22203
921 E. Fort Avenue, Suite 100, Baltimore, MD 21230
630 Peter Jefferson Pkwy. Suite 130, Charlottesville, VA 22911
17577 Nassau Commons Blvd, Suite 203, Lewes, DE 19958

RELEASE OF INFORMATION FORM

I authorize **Bloom Health Centers** to release/obtain the following information noted regarding mental health records for:

Patient Name: _____ DOB: _____

From the treatment period of: _____ to _____

This information should be (**CHECK ONE ONLY**) _____ **RELEASED TO** _____**OBTAINED FROM**

Please indicate how you would like your records sent to

Name_____
Email address: _____
If sent via email, recipient will receive a link to download files from Bloom's secure Egnyte system via email
Fax – number: _____-_____-_____
Physical copies mailed to address: _____
_____
Physical copies picked up at one of BHC's locations above: _____
Other - _____

For the purpose of:

_____ Coordination of care
_____ Continuing care
_____ Background information
_____ Evaluation
_____ At the request of the individual

Select the specific type(s) of records to released:

_____ All medical information
_____ Evaluation/ progress reports
_____ Medications
_____ Psychological evaluation and reports
_____ Billing, scheduling, and attendance information

I understand this consent is valid for 12 months from the date signed, unless otherwise revoked in writing. As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom the disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

Signature: _____ Date: _____

Printed Name/ Legal Guardian: _____