Convergent Mental Health and Wellness, LLC
213 Old Padonia Rd, Cockeysville, MD 21030
443-840-8994

Release of Confidential Records and Information (ROI) Authorization

Client Full Name:

Phone Number:

DOB (MM/DD/YYYY):

Your relationship to the client:

- ❑ **Self**
- ❑ **Parent or Legal guardian**
- ❑ **Personal Representative**

I hereby authorize Convergent Mental Health and Wellness to give/receive information regarding my treatment to/from the following Individual or Organization:

_____
Name of Individual/Organization

_____
Individual / Organization's Address

_____
Phone / Fax Number / Email Address

I give my permission to give and receive information for the purposes of:

- ❑ **Coordination of care**
- ❑ **Determining eligibility for benefits or program**
- ❑ **Referral to other services**
- ❑ **Billing and payment**
- ❑ **Updating files**

I give permission for the following types of information to be released to the above indicated party:

- ❑ **Intake and discharge information**
- ❑ **Mental health diagnoses and evaluations**
- ❑ **Clinical treatment summary**
- ❑ **Treatment plan goals (including symptoms)**
- ❑ **Progress notes**

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent it anytime within 365 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 365 days from the date on which it is signed, or upon fulfillment of the purpose of stated above. I understand my typed signature is equivalent to a written signature.

_____ _____
Client / Guardian Signature **Today's Date (MM/DD/YYYY)**