AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Montgomery County Department of Health and Human Services



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1	FAX		1 1 1		
	separate form for each person or agency v			G. DM	
Client Last Name	First Name	Middle Initial	Date of Birth	Sex M	
. The above named progr	am of the Montgomery County De	 partment of Healt	l h and Human Se	rvices (DHH	S) ha
my permission to:	am of the Monegomery Soundy De			JI (1005 (23111	<i>(</i>) 110
	n verbally discuss the informa	tion checked belo	w with:		
Address:					
Initial all items covered by the	is release. *Initial if you are a contract agenc	veguesting the ITM and	l want to invite other e	contract agoneies	
		requesting the 11M and	want to invite other c	contract agencies.	
_	record (includes all items below)				
	t Treatment Plan _	Progress Not	es	Diagnosi	S
Psychiatric Evalu	ation Service Summary	Psychologica Psychologica	l Evaluation		-
Lab Results	Medication Record	History and I	Physical		
	ug treatment records. Specify belo			disclosure	
	ssment results and history		_		
Summary of treat	tment and service plan progress and	compliance			
Other (specify)					_
	ITTC f 41	. • 1 • 1	-		
	is being shoved				
3. Reason this information	is being shared				
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