

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR BEHAVIORAL HEALTH/MENTAL HEALTH AND ADHD MEDICATION MANAGEMENT FOR CONTINUITY OF CARE**

The patient below is requesting to transfer management of behavioral health/mental health care and ADHD medication management during the academic year to Towson University Health Center. All fields are required with complete information to facilitate transfer of care.

**Patient Name:** \_\_\_\_\_ **Patient Phone #:** \_\_\_\_\_

**Client Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **TU Student ID #:** \_\_\_\_\_

**Client Address:**

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(street) (city) (state) (zip)

I, \_\_\_\_\_, hereby authorize the release of information from the provider or agency below to facilitate the transfer of my care to Towson University Health Center. In addition to the information contained on this form, I authorize the release of my treatment record including clinical interview notes, testing and assessment reports and/or completed self-report measures, and medication history. I also authorize the exchange of information between the Provider/Agency and Towson University Health Center for the purposes of care coordination.

**Provider/Agency Name:** \_\_\_\_\_

**Provider/Agency Phone # :** \_\_\_\_\_ **Provider/Agency Fax # :** \_\_\_\_\_

**Provider/Agency Address:**

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(street) (city) (state) (zip)

This consent is effective on \_\_\_\_\_ and expires on \_\_\_\_\_.  
(today's date) (no greater than 1 year from today's date)

I understand that I may revoke this consent at any time within the effective period by written request.

**Client signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*NOTICE: This information has been disclosed from confidential records. Any further disclosure without the specific written consent of the person to whom it pertains is prohibited, except as provided by law. For example, should a counselor be legally and/or ethically required to take responsible action, including, but not limited to, where there is danger of imminent harm to self or others, or in the case of apparent child abuse, information included in confidential records may be further disclosed without specific written consent as prescribed by law.*

**TO BE COMPLETED BY ADHD TREATING PROVIDER**

Date of clinical evaluation for ADHD: \_\_\_\_\_ ICD-10 diagnosis code(s): \_\_\_\_\_

Relevant history and supporting information for diagnosis of ADD/ADHD:

*Please provide copies of records or any administered tests (including self-report forms, semi-structured interviews, etc.) that were used for evaluation and diagnosis.*

List medications prescribed in treatment of ADHD, including name of medicine, dose strength and schedule, as well as notes related to response or adverse effects:

Date, dose, and quantity of last stimulant prescription:

Any additional diagnoses or treatment provided:

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**Provider Name (please print)**

**Date**

Please fax completed form and all attachments to Towson University Health Center at (410) 704-3715. For questions, please contact the clinic at (410) 704-2466.