

CHARLES COUNTY HUMAN SERVICES PARTNERSHIP

P.O. Box 2150
La Plata, MD 20646
Tele: (301) 396-5238 Fax: (301) 396-5248

Release of Information

I hereby give my permission to the Charles County Human Services Partnership to release and obtain the following types of information from: _____

- | | | |
|---|--|-------------------------|
| _____ Entire Medical Record | _____ School Records | _____ Discharge Summary |
| _____ Psychological Evaluation | _____ Psychiatric Evaluation | _____ Progress Notes |
| _____ Dept. of Social Services Records | _____ Department of Juvenile Justice Records | |
| _____ Department of Substance Abuse Records | _____ Other _____ | |

concerning _____
Name Date of Birth

I understand this information will be used to assist in developing and providing an appropriate program for me.

Signature **Date**

I understand this information will be used to assist in developing and providing an appropriate program for my child.

Signature and Relationship to child **Date**

This release of information is valid for one year unless the signatory party specifies an earlier date.