Marie Caterini Choppin, LCSW-C & Associates
LOTUS POINT WELLNESS, INC.

AUTHORIZATION TO RELEASE OR EXCHANGE INFORMATION

I, _____, (hereinafter "Client") hereby authorize
(*Name of client or parent/guardian/legal representative)*

LOTUS POINT WELLNESS, INC, (hereinafter "Provider") **to disclose AND/OR obtain information**

regarding myself or my child(ren)

_____, *D.O.B.* _____
(Name of Client/Child)

with _____
(Name /Address/Phone Number for disclosure)

The purpose of this disclosure is to improve assessment and treatment planning, share relevant information regarding treatment, and when appropriate, to coordinate treatment services.
If other purpose, please specify: _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Lotus Point Wellness, Inc. at 4405 East-West Highway, Suite 508, Bethesda, MD 20814.

Lotus Point Wellness, Inc. shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form. Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

This authorization shall remain valid for one year from date signed.

_____ _____
Signature of Client/Guardian/Legal Representative *Date*

_____
Printed Name of Client/Guardian/Legal Representative

_____ _____

THERAPIST SIGNATURE *Date*

Printed Name of Therapist *Date*

13200 New Hampshire Avenue
Silver Spring, MD 20904

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