Maryland Anxiety & Depression
TREATMENT CENTER, LLC

Authorization for Release of Private Health Information

Patient Name _____ Date of Birth _____

Address _____ Telephone Number _____

I authorize the Maryland Anxiety and Depression Treatment Center and all staff members to

□ Obtain private health information from □ Release private health information to

_____ for the purpose of ongoing psychiatric care.

This information is to include the following:

□ Intake notes
□ Progress notes
□ Diagnoses
□ Medications prescribed
□ Psychiatric records
□ Substance abuse treatment records
□ Laboratory results
■ Discharge summaries

Please include records of treatment between _____ (date) and _____ (date)

This authorization will be valid until one year from the date signed below, or until _____ (date)

I understand that authorizing this disclosure is voluntary, and I have the right to refuse to sign this form. I understand that I may withdraw this authorization at any time. I acknowledge that the material released may contain information about drug and alcohol use, HIV testing results, and information about physical and sexual abuse. I understand that it is forbidden for private health information to be released to or obtained from anyone other than the above individual without written consent. I understand that the information may be subject to redisclosure by the recipient unless it is protected under federal confidentiality rules. This facility or person is released and discharged from any liability, and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Private Health Information" form.

_____ _____

Signature Date