www.pamllc.us

AUTHORIZATION TO RELEASE / OBTAIN MEDICAL RECORDS

Name: _____ Date of Birth_____

Address:_____

_____

City: _____ State:_____ Zip_____

AUTHORIZES: Psych Associates of Maryland, LLC

Address Line1: _____ PHONE: (410)-823-6408

Line 2: _____ FAX: _____

TO: ☐ Release ☐ Medical ☐ Psychiatric ☐ Drug & Alcohol Information
☐ Obtain ☐ Medical ☐ Psychiatric ☐ Drug & Alcohol Information

RELEASE TO or OBTAIN INFORMATION FROM

Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #:_____

PERSON/AGENCY/BUSINESS:

☐ DSS ☐ DJS ☐ School

☐ Parent ☐ Self ☐ Doctor

☐ Court ☐Attorney ☐ Parole

☐ Probation ☐ Therapist

☐ Others

TYPE OF PROGRAM/TREATMENT:

☐ Inpatient Treatment ☐ PHP/Day Treatment ☐ Group Home
☐ Outpatient Treatment ☐ Residential Treatment ☐ Other: _____
FOR THE TREATMENT PERIOD OF: From: _____ Through: _____

REASON/PURPOSE FOR RELEASE/DISCLOSURE:

☐ Continuing Care ☐ Placement ☐ Disability Determination/SSI
☐ Legal Proceedings ☐ Parent/ Legal Guardian request ☐ Insurance
☐ Educational Purposes ☐ Other: _____

INFORMATION TO BE RELEASED/OBTAINED:

☐ History & Physical ☐ LabX-Ray/EKG ☐ Discharge Summary (clinical)
☐ Psychosocial Assessments ☐ Treatment Plans & updates ☐ Discharge Summary (Nursing)
☐ Psychiatric Evaluations & Notes ☐ Consultations/Referrals ☐ Discharge summary (Medical)
☐ Progress Notes (Clinical) ☐ Dates of Treatment ☐ Medications/Medication History
☐ Other: _____

RECORDS WILL BE SENT BY: ☐ FAX ☐ USPS ☐ Hand Delivered ☐ Held for Pick-up ☐ Email

I understand that federal regulations 42 CFR part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, protects and prohibits disclosure without my written consent unless otherwise Provided for in the regulations. I also understand that I may revoke authorization except to the extent that action has been taken and not retroactive to release of information already made in good faith. I understand that this authorization will automatically expire in 12 months from date signed.

Patient/Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Witness Signature: _____ Date: _____