White Marsh Psychiatric Associates, LLC
5024 Campbell Boulevard, Suite H • Baltimore, Maryland • 21236 • Phone 410-931-9280 • Fax 410-931-6694

Authorization for Release of Confidential Information

Patient _____ Social Security Number _____ Date of Birth _____

Address _____ Telephone Number _____

I authorize the release of confidential records of the above named patient:

Purpose ☐ Coordination of Care ☐ Other _____

From (1) White Marsh Psychiatric Associates, LLC . Specify provider(s): _____

(2) and/or ☐ Name: _____

Address _____ City . State . Zip Code _____ Telephone Number _____

To (1) ☐ _____

Address _____ City . State . Zip Code _____ Telephone Number _____

(2) ☐ White Marsh Psychiatric Associates, LLC

This authorization includes the release of the following information:

☐ Mental health records ☐ Admission history and physical ☐ Consultation reports ☐ Discharge Summary only
☐ Emergency room records ☐ Lab reports ☐ School Records
☐ Drug and Alcohol treatment records (see Notice below regarding Federal law Confidentiality Requirements
☐ Other (Specify _____)

Dates of treatment: from _____ to _____

I understand that I have the right to inspect and receive a copy of the information to be disclosed and I may revoke this authorization at any time in writing, except to the extent that the action has been taken based on this authorization. This authorization will expire one year from the date signed below unless specific expiration or condition is named here: _____
I understand that I have the right to refuse to sign this Authorization for Release of Confidential Health Information and that my treatment is not conditioned on my signing this authorization.

I have read the above and authorize White Marsh Psychiatric Associates, LLC, and or their treating facility or practitioner named above to disclose such information as herein described. I acknowledge that the records authorized for release may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I understand that disclosure of this health information to a party other than the one designated above is forbidden without an additional authorization on my part. I understand that health information used or pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2. White Marsh Psychiatric Associates, LLC, their treating facility, and /or practitioner(s) are released and discharged of any liability and the undersigned will hold White Marsh Psychiatric Associates, LLC, their treating practitioner an/or facility harmless for complying with this authorization.

Signature of Patient _____ Date _____

Signature of Parent/Guardian/Authorized Representative* _____ Date _____

Signature of Witness _____ Date _____

*State basis for authority to give consent on patient's behalf: _____

☐ Medical care power of attorney, guardianship, or court order (Copy to be attached.)

Notice to Recipient Re: Prohibition of Redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules 42 CFR Part 2. These federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. **A general authorization for the release of medical or other information is NOT sufficient for this purpose.** The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.