White Marsh Psychiatric Associates, LLC

5024 Campbell Boulevard- Suite H

Baltimore, Maryland 21236

Phone: (410) 931-9280 Fax: (410) 931 -6694

SPECIFIC AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I _____, authorize and request White Marsh Psychiatric Associates,
(Patient's name)
LLC, to disclose my/ my child's protected health information to the party or parties listed below.

The request includes (choose all that apply):

- ☐ Scheduling
- ☐ Billing Information
- ☐ Medications
- ☐ Diagnosis

This is NOT an authorization to release a copy of my medical records. I understand that I can withdraw this authorization in writing at any time.

NAME	RELATIONSHIP TO PATIENT

Patient Signature: _____ Date: _____
Signature of parent/guardian/personal representative

Please include representative information below if applicable

Name: _____ Relationship: _____ Date: _____
Name of guardian/personal representative (Please Print)

Witness Signature: _____ Date: _____