Myers Health and Wellness LLC

Patient Release

Patient Name: _____ D.O.B: _____

This form when completed and signed by you authorizes the release of protected information from your clinical record to Myers Health and Wellness LLC.

I authorize the exchange of information between the following:

Information to be released to/from:	Information to be released to/from:
Name: _____	Myers Health and Wellness LLC.
Relationship: _____	8441 Belair Rd Suite G1
Phone: _____	Baltimore MD 21236
Fax: _____	Phone 410-904-7921
Address: _____	Fax 410-904-7922

Purpose of release:

Coordination of Care ____ Request of the individual ____Legal Representation ____Insurance ___ Other _____

The authorization is only for the limited purpose of obtaining from or releasing information to, discussing my case with these individuals or companies for the specific purpose of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information. I understand that information may be shared in writing, via email, in electronic form, and/or in meetings or by telephone. This release will automatically expire 12 months from the date of signature. I understand that I can withdraw this consent at any time by submitting a written revocation to Myers Health and Wellness LLC. The revocation will not apply to information that has already been released. I understand that information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may then be no longer protected under the HIPPA Privacy Rule.

_____ _____ Patient Signature /Date

_____ _____ Witness/ Date