Lake Linganore PSYCHIATRY

11670 Old National Pike, Suite 103
New Market, MD 21774
Tel 240-744-7582 Fax 888-744-2504
www.lakelinganorepsychiatry.com

Medical Information Release Form

Patient Name: _____
Address:_____
_____
Date of Birth: _____

I hereby authorize:

Lake Lingnaore Psychiatry
Phone: 240-405-8084
Fax: 888- 744-2504

to release necessary medical information including the diagnosis, records, examination rendered to me (or child named above, if a minor) and/or claims information to:

Recipient:_____
Phone:_____
Fax:_____

The Release of information will remain in effect until terminated by me in writing.

Signed: _____ Date: _____
Relationship: _____