



PsychNP Wellness Center, LLC.
 658 Kenilworth Drive Suite 206
 Towson, MD 21204
 Phone: (443) 841-7550 Fax: (443) 841-7572

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 PsychNP Wellness Center, LLC.

I authorize the exchange of information between the following:

Information to be released to/from:

Information to be released to/from:

Name: _____
 Relationship: _____
 Phone: _____
 Fax: _____
 Address: _____

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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 PsychNP Wellness Center, 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