The Anxiety and Stress Disorders Institute of Maryland, LLP
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Authorization to Release Health Care Information

Patient's name _____ Patient's date of birth _____

I, _____, request and authorize the exchange of health care information between ASDI and the individual(s) or organization(s) shown below. This authorization expires on _____. *If a date is not specified, this authorization expires in one year.*

Individual or organization: _____

Address: _____

Phone number: _____

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based on my request. There are two ways to cancel this request: 1) write, sign, and date a letter to ASDI revoking this authorization or 2) sign, date, and write "cancel" on this original form. Once information is released, ASDI has little control over it. The recipient might re-disclose the information. Privacy laws may no longer protect the information.

I agree to the release of health care information (testing, diagnosis, or treatment) when applicable for:

☐ Psychiatric disorder/mental health ☐ Drug/alcohol use ☐ Sexually transmitted disease ☐ HIV/AIDS

Patient/authorized individual's signature: _____ Date: _____

Printed name: _____

Relationship to patient: _____