



**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL  
HEALTH RECORDS / PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

☐ Share my PHI with

☐ Obtain my PHI from

Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Fax: \_\_\_\_\_

Data shall include:

☐ Psychiatric records    ☐ Psychotherapy notes    ☐ Psychological testing records

☐ Other (including what you don't want sent): \_\_\_\_\_

For the following dates of service: (enter specific date(s) or date range): \_\_\_\_\_

Note: Records include the substance of any communication made by the patient to the provider in confidence during or in connection with the provision of health services, or information otherwise acquired by the provider about the patient in confidence and in connection with services the patient receives from the provider.

Specific purpose: ☐ Continued/Coordinated care ☐ Other, please specify \_\_\_\_\_

Expiration of Authorization:

This authorization will expire five (5) years from the date written below or upon the following date or occurrence of the following event (if none, write N/A): \_\_\_\_\_

I understand that 1) I have a right to inspect my confidential health records/Protected Health Information as allowed under applicable law; 2) The Family Center LLC may disclose my PHI without my consent only in specific circumstances authorized by law; 3) my treatment provider may refuse to disclose or allow my inspection of part or all of my PHI if the provider believes that disclosure or inspection is not permitted or is otherwise restricted by applicable law; 4) Maryland law provides additional protections for mental health information; 5) The Family Center LLC may disclose my PHI without my consent only in specific circumstances authorized by law; and 6) my treatment provider may refuse to disclose or allow my inspection of part or all of my PHI when otherwise permitted by law.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_