AUTHORIZATION FOR RELEASE OF INFORMATION

DO NOT RELEASE INFORMATION IF THIS AUTHORIZATION IS NOT COMPLETELY FILLED OUT – ALL BLANKS MUST BE COMPLETED

Patient Name: ____

Address: ____ Date of Birth _____________________

City ____________________________ State ______ Zip Code ___________ SS# _____________________

Home Telephone Number ______________________ Work Telephone Number _________________________

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure

   Name ____

   Address ____
3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

   ☐ Mental health treatment summary – date(s) __________ ☐ Psychotherapy notes – date(s) _____________

   ☐ Medical treatment summary – date(s) __________ ☐ Psychological/Educational Testing_________________

   ☐ Other _________________________________
4. If this authorization is for release of medical records, I understand that I am giving my permission to release copies of information in my medical record that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing or treatment of sexually transmitted disease, unless indicated in the following instructions:______________________________
5. This information may be disclosed to and used by the following individual:

   Name: Patrick Barta, MD PhD

   Address: Suite 401, 101 E Chesapeake Avenue, Towson, MD, 21286

   Voice number:. 443 470 9101

   Fax number: 410 337 8084

   For the purpose of my treatment with Dr. Barta.
6. I understand that I have a right to revoke this authorization at any time. My revocation becomes effective when delivered in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire one year from the date signed, unless an expiration date, event or condition is specified as follows: ____
7. I understand there may be a fee if I request copies for individuals or organizations.

____ ________________________________

Signature of Patient or Legal Representative Date

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If Signed by Legal Representative, Describe Authority to Act on Patient's Behalf