Authorization for Release of Mental Health Information

Patrick Barta, MD PhD
Suite 401, 101 E Chesapeake Ave
Towson, MD 21286
410 337 8084

Patient Name: _____ Birthdate: _____

Maiden or other name (if applicable)_____

I request and authorize Dr. Patrick Barta to release my mental health information to:

Name: _____ Phone/Fax: _____

Address: _____

City, State: _____ Zip code: _____

This authorization is subject to the following **restrictions** (if any):

_____

Treatment during the following time period or dates: ☐ All ☐ Other _____

The following will **not** be released unless you specifically authorize it by marking the relevant box:

- ☐ I specifically authorize the release of information pertaining to drug and alcohol abuse.
- ☐ I specifically authorize the release of HIV/AIDS test results.
- ☐ I specifically authorize the release of genetic testing information.
- ☐ I specifically authorize the release of psychotherapy notes.

Purpose(s) of this use/disclosure:

- ☐ At my request.
- ☐ Treatment purposes.
- ☐ Other (state reason):_____

Authorization expires: _____(date) If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

- I understand that I may revoke this authorization at any time by making a written request to Dr. Barta, except to the extent that action already has been taken in reliance on this authorization.
- I understand that my signing is voluntary, and Dr. Barta may not condition treatment or payment on my signing this authorization. A third party may require this authorization to obtain information in connection with eligibility or enrollment in a health plan, or to determine their obligation to pay a claim.
- I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient of this information, and no longer protected by federal privacy regulations.
- I understand I am entitled to receive a copy of this Authorization.

Signature (patient or authorized representative) _____

Date: _____

Relationship/authority (if signed by authorized representative): _____

Witness (only if patient unable to sign): _____