AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This authorization for the use or disclosure of my health information is required by state and federal law.

PATIENT'S NAME: _____ DOB: _____

PHONE NO. _____ SOCIAL SECURITY NO. _____

I hereby authorize the use or disclosure of my health information

Name of person/organization releasing information: _____

Address: _____

Phone and/or fax: _____

To release my information to:

Heal Thyself, LLC
4000 Mitchellville Road, Ste A308 Bowie, MD 20716
Phone: 301-850-2069 Fax: 301-893-7584

This authorization applies to the following information: (circle all that apply)

All records Labs Imaging Reports Immunizations Other

The Recipient May Use My Health Information Only For The Following purpose

Please specify on line below: _____

A SPECIFIC AUTHORIZATION IS REQUIRED TO RELEASE INFORMATION REGARDING THE FOLLOWING:

HIV INFORMATION DRUG/ALCOHOL INFORMATION MENTAL HEALTH INFORMATION

(please circle all that apply)

This authorization shall be valid until _____ Please indicate a date after which no information can be released. If no date is given, authorization is valid for 90 days only. I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment. I may revoke this authorization at any time, in writing. The revocation must be signed by me or on my behalf and sent to the address indicated on this form. The revocation is effective upon receipt but will have no impact on uses or disclosures made while the authorization was valid.

Patient Signature _____ Date: _____