* REQUIRED INFORMATION

Consortium Health and Rehab Center.

3240 Belair Rd, Baltimore, MD 21213

Phone - 443.759.9573

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I Enter patient name here authorize

at the above address to:

PATIENT DATE OF BIRTH *

Enter date of birth here

☐ Receive my medical history information from the following physicians:

NAME	ADDRESS
Enter name here	Enter address here

NAME	ADDRESS
Enter name here	Enter address here

☐ Receive my treatment records from the following therapist:

THERAPIST NAME	THERAPIST ADDRESS

Enter name here

Enter address here

☐ Release my treatment information/records to the following healthcare professionals:

NAME

ADDRESS

Enter name here

Enter address here

NAME

ADDRESS

Enter name here

Enter address here

☐ Release my treatment information to the health insurance company listed below for billing / authorization purposes.

INSURANCE PROVIDER NAME

INSURANCE PROVIDER ADDRESS

Enter name here

Enter address here

☐ This information is for the following purposes (any other use is prohibited).

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated by the physician specified above unless I withdraw my consent during treatment. This consent will expire 5 years from date of signature.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

PATIENT NAME *

Enter name here

PATIENT SIGNATURE *

DATE

Clear

PARENT/GUARDIAN NAME *

Enter name here

PARENT/GUARDIAN SIGNATURE *

DATE

Clear

WITNESS NAME *

Enter name here

WITNESS SIGNATURE *

DATE