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Crofton, MD 21114
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Release of Information or Medical Records Request Form

I authorize Therapeutic Health to release and receive the information indicated to the agency or persons listed below for the purposes of service coordination and continuity of care.

Patient Name _____ Date of Birth _____

Information to be released:

_____ Admission Note & Discharge Summary
_____ Psychiatric Evaluation
_____ Problem List/Medication List
_____ Most recent progress Note
_____ Verbal Exchange
_____ Other:_____

_____ Neurological Evaluation
_____ Psychological Evaluation
_____ Labs results (past year)
_____ Test results (MRI, etc)
_____ EKG results (past year)

We are Requesting Information from: _____ We are Releasing Information to: _____

Agency or Person	Address	Phone/Fax
_____	_____	_____
_____	_____	_____
_____	_____	_____

- This authorization is for the purpose of obtaining from or releasing information to individuals or companies for the specific purpose of evaluation and treatment.
- I understand that I can withdraw this consent at any time by submitting a written revocation to Therapeutic Health Associates.
- The revocation will not apply to information that has already been released.
- I understand that if information was already released, Therapeutic Health Associates cannot prevent the recipient from further disclosing the information.
- This release will automatically expire 12 months from the date of signature.

_____ _____
Patient Signature Date

_____ _____
Clinician Signature Date