WELLCORE PSYCHIATRY OF MARYLAND, LLC

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Patient Name: _____ Patient Date of Birth: _____

I, _____hereby request and authorize WELLCORE
(name of person signing release)

PSYCHIATRY OF MARYLAND, LLC, to release/request healthcare information of the above-named patient to the following person/organization:

Name: _____ Relationship to Patient: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

This request and authorization applies to:

_____ Any and all healthcare information

_____ Specific healthcare information relating to the following treatment, condition, or dates: _____

_____ Other: _____

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person/entity listed above.

Yes No I authorize the release of any pertinent healthcare Information to the aforementioned person/entity for up to 180 days after discharge from WELLCORE PSYCHIATRY OF MARYLAND, LLC.

Signature: _____ Date: _____