Alvord | Baker & Associates, LLC
3200 Tower Oaks Blvd., Suite 200 Rockville, MD 20852 Phone: 301-593-6554 Fax: 301-255-0461
8401 Connecticut Ave., Chevy Chase, MD 20815 Phone: 301-593-6554 Fax: 301-754-1034

Authorization Form for Release of Clinical Record

This form when completed and signed by you, authorizes us to release protected information from your clinical record to the person you designate.

Patient's Name: _____ Birth Date: _____

Address: _____

_____ Phone: _____

I, _____, authorize Alvord, Baker & Associates, LLC to

☐ **Release** from my record ☐ **Receive** from my record

_____

Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.

I am requesting that Alvord, Baker & Associates, LLC release this information for the following reasons: *("at the request of the individual"* is all that is required if you are my patient and you do not desire to state a specific purpose.*)*

_____

I understand that my therapist cannot re-disclose information he/she received from another health care provider if that health care provider requested that the information not be re-disclosed.

This authorization shall remain in effect for a period of one year from the date below or until _____.

The information is to be released to/released from:

Name: _____ Position: _____

Address: _____

Phone: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Alvord, Baker & Associates, LLC. However, the revocation will not be effective to the extent that action taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my therapist(s) generally may not condition psychological services upon the signing of an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Patient or legally authorized individual signature Date

_____

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.