Print Form

PLAN of Maryland-D.C., Inc.
604 South Frederick Ave, Suite 411
Gaithersburg, MD 20877

Authorization for the Exchange of Health Information

Client's Name: _____ Date of Birth: _____

Address: _____ Social Security No. _____

_____ Phone No. _____

To: _____

_____

Through this document I authorize you to provide information to PLAN of Maryland-D.C., Inc. and authorize PLAN of Maryland-D.C., Inc. to provide information to you. This information may include all pertinent records related to psychiatric and medical treatment.

I understand that the information shared may be used only for the purpose of providing assessment, treatment and coordination of services for me, and will not be released to another party.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Executive Director of PLAN of Maryland-D.C., Inc. at the address noted above. I further understand that if I revoke this authorization the revocation does not apply to information that was shared prior to the revocation and in reliance on this authorization.

Unless it is revoked this authorization is effective for one year from the date on which it is signed.

I understand that PLAN of Maryland-D.C., Inc. will not condition providing services to me based on my signing this authorization.

I understand that unless I have specified otherwise in writing, PLAN of Maryland-D.C., Inc. reserves the right to disclose this information in any form including orally, in writing, or by electronic means.

I have been offered a copy of this authorization for my records.

Signature of client or responsible party	Signature of Witness
Date	Date