Heitt Clinical & Corporate Consulting, LLC
Michael Heitt, PsyD
Licensed Psychologist
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Baltimore, Maryland 21208
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Phone 410-580-9047
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

For this authorization, "My Health Information" includes *[list what you want to be disclosed (e.g., evaluation results, diagnosis, treatment plan, etc.)]* _____

for the date(s) of service starting *[note when evaluation or therapy started]* _____

I authorize Michael Heitt, PsyD to disclose My Health Information to *[name(s), phone numbers, addresses and email addresses TO whom you authorize Dr. Heitt to disclose information]* _____

_____

_____

If Dr Heitt is to be the recipient of the information, I authorize the following health care provider to disclose My Health Information to Dr Heitt:

Name and address/phone of other health care provider *[name(s), phone numbers, addresses and email addresses FROM whom you authorize Dr. Heitt to receive information (this is probably the same as those listed in the "TO" field above)]* _____

_____

for the following purpose(s) *[list why you are requesting this disclosure (e.g., "coordination of care," "per my request," etc)]* _____

_____

_____

I understand there may be a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland State guidelines. By signing this authorization, I agree to pay these fees at the time this request is made.

This authorization is valid for one year from date signed unless revoked, or as specified here: _____

I understand that once My Health Information is disclosed as requested in this authorization My Health Information may no longer be protected by federal and state privacy laws and potentially may be re-disclosed by the person who is receiving my information if that person is not already obligated to follow such federal and state privacy laws.

I am not required to sign this authorization. Health care providers, including Dr Heitt, are not permitted to withhold treatment based upon the signing of this form. If I do not sign this authorization, the appropriate health care provider, including Dr Heitt, will not disclose My Health Information as requested. I will receive a copy of this authorization upon signature.

I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to:

Michael Heitt, PsyD
8 Reservoir Circle, #105
Baltimore, MD 21208

or to the other healthcare provider named on the first page of this form.

Your Name: _____ Signature: _____

Phone: _____ *[If unable to sign electronically, please sign by retyping your name using ALL CAPS]*

Date of Birth: _____ Date: _____