Peter M. Levine, M.D., LLC
8518 Rayburn Road Bethesda, MD 20817
TEL 301/907-0090 FAX 301/907-0093

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.

Patient Name _____

Address _____

_____

Date of Birth _____

For this authorization, "My Health Information" means (check all that applies) and may include information regarding substance abuse treatment:

Hospital Records

____Emergency Room Record
____Admission Physical
____ Psychosocial Assessment
____Drug & Alcohol Treatment Record
____Psychiatric Admission Note
____Psychiatric Evaluation/Diagnosis
____Progress Notes
____Discharge summary
____Diagnostic Tests/Results (Lab, X-rays, and other Test Results)
____All of the above
____Other_____

Outpatient Records

____ Initial Biopsychosocial Evaluation
____Medication Records
____Psychological Testing
____ Medical Records
____ Progress notes
____Treatment Plans
____Summary of Treatment
____ All of the above
____Other _____

For the date(s) of service starting/ending_____

I authorize Peter M. Levine, M.D. to _____Release My Health Information
_____Receive My Health Information

From/To Name _____

Address _____

_____

For the following purpose:

_____Coordination of medical care, including obtaining or providing history, current or past treatment, including psychological and psychiatric records and treatment
_____ Providing information to workplace or insurance for disability, leave of absence, or to assist in payment
_____ Obtaining or providing collateral information to aid in history and treatment planning and facilitate care
_____ Providing clinical information to state or regulatory agencies
_____ Other: _____

I understand that I have the right to receive a copy of this authorization. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Peter M. Levine, M.D., LLC, 8518 Rayburn Road, Bethesda, MD 20817. I understand that a revocation is not effective to the extent that the Practice has relied on this authorization in its actions. I certify that I have read, signed and received a copy of this authorization upon my request. I understand I may be billed for copies of my medical record according to HIPAA State of Maryland and Federal Law.

Patient's Signature_____ Date_____