Peter M. Levine, M.D., LLC
5480 Wisconsin Avenue, Suite 212 Chevy Chase, MD 20815
TEL 301/907-00090 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 apply) 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, 5480 Wisconsin, Suite 212, Chevy Chase, MD 20815. 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_____