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**Consent for Release of Protected Health Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize:

Patricia Frischtak ,MD AND \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6500 Seven Locks Road, Suite 204 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cabin John, Maryland 20818 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release and exchange the following information:

\_\_\_\_\_Verbal and written Protected Health Information for consultation, evaluation and treatment

\_\_\_\_\_ Other

I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying, in writing, DR PATRICIA FRISCHTAK. However, a revocation will not affect any actions taken by DR PATRICIA FRISCHTAK prior to their receipt of the revocation.

I understand I may refuse to sign this authorization.

Signature of Patient. Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient