

Nathaniel A. Sawyer, LCSW-C

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AUTHORIZATION TO RELEASE AND OBTAIN HEALTHCARE INFORMATION

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| --- | --- | --- | --- |
| Patient’s Name: |  | Date of Birth: |  |
| Previous Name: |  | Social Security #: |  |
| I request and authorize | Nathaniel A. Sawyer, LCSW-C | to |
| release and obtain healthcare information of the patient named above to/from: |
|  | Name: |  |
|  | Address: |  |
|  | City: |  | State: |  | Zip Code: |  |
| This request and authorization applies to: |
| [ ]  Healthcare information relating to the following treatment, condition, or dates: |  |
|  |       |
| [ ]  All healthcare information |
| [ ]  Other: |       |
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| [ ]  Yes [ ]  No | I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. |
|  |
| [ ]  Yes [ ]  No | I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. |
| Patient Signature: |  | Date Signed: |  |
| Parent Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(If patient is under 18) |
|  |
| THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED OR WHEN TREATMENT IS TERMINATED. THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME. |