

Nathaniel A. Sawyer, LCSW-C

18502 Office Park Drive, Montgomery Village, Maryland 20886

Phone: (301) 509-9359

AUTHORIZATION TO RELEASE AND OBTAIN HEALTHCARE INFORMATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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. | | | | | | | | | | | | | | | | | | | | |