Adult Attention Deficit Disorder
Center of Maryland

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INFORMATION RELEASE FORM

Name of patient:____

Date of birth:____

Social Security Number:_____________________________________

- ◻ I hereby request and authorize the Adult Attention Deficit Disorder Center of Maryland to release any and all information concerning my medical condition to:____
- ◻ I hereby request and authorize you to furnish to the Adult Attention Deficit Disorder Center of Maryland any and all information/records regarding physical and/or mental examination or condition.
- ◻ Psychiatric discharge summary date:________________________
- ◻ Medical discharge summary date:__________________________
- ◻ Brief review of psychopharmacologic trials with benefits and side effects.
- ◻ Brief medical/psychiatric diagnostic review of the patient.
- ◻ Neurologic workup date:_____________________________________

- I understand that all information is to be kept confidential and is for use by professionals involved in my care.
- I understand that I may revoke this authorization at any time by notifying the Adult Attention Deficit Disorder Center of Maryland in writing.
- I understand that once information has been disclosed, we cannot guarantee protection of its confidentiality.
- I understand that my treatment is not contingent upon my signing this document.
- I understand that information may include information regarding treatment of mental health, physical illness, and substance abuse, as well as HIV and AIDS, if applicable.
- My authorization to release information will expire one year from the date of signature.

______________________________ ______________________________

PATIENT'S SIGNATURE WITNESS' SIGNATURE

______________________________ ______________________________

DATE DATE

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