Patient Release

Patient Name:________________________________D.O.B: _________________

This form when completed and signed by you authorizes the release of protected information from your clinical record to ProCare Wellness LLC.

I authorize the exchange of information between the following:

Information to be released to/from:

Name: _________________________

Relationship: ____________________

Phone _______________ __________

Fax:____________________________

Address: ________________________

Information to be released to/from:

ProCare Wellness LLC.

11155 Dolfied Blvd., Suite 116

Owings Mills, MD 21117 Phone

443-257-5896

Purpose of release:

Coordination of Care____________________ Request of the individual _________________________________

Legal Representation_________________________Insurance_________________Other __________________

The authorization is only for the limited purpose of obtaining from or releasing information to, discussing my case with these individuals or companies for the specific purpose of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information. I understand that information may be shared in writing, via email, in electronic form, and/or in meetings or by telephone. This release will automatically expire 12 months from the date of signature. I understand that I can withdraw this consent at any time by submitting a written revocation to ProCare Wellness LLC. The revocation will not apply to information that has already been released. I understand that information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may then be no longer protected under the HIPPA Privacy Rule.

____ Patient Signature /Date

____ Witness/ Date