WASHINGTON
BEHAVIORAL MEDICINE
ASSOCIATES, LLC

5480 Wisconsin Ave., Suite 223
Chevy Chase, Maryland 20815
Ph: 301-576-6044
Fax: 301-576-1645
www.WBMA.cc

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____
Patient's Address: _____
Patient's Contact Number: _____ Fax Number: _____
Previous Names: _____

RELEASE OF INFORMATION ☐To ☐From ☐Exchange (check all that apply)

WBMA CONTACT INFORMATION

WBMA, LLC
5480 Wisconsin Avenue Suite #223
Chevy Chase, MD 20815
Phone: 301-576-6044
Fax: 301-576-1645

EXTERNAL CONTACT INFORMATION

Name/Facility: _____
Address: _____
_____
Phone/Fax: _____
_____

I AM REQUESTING RECORDS AND/OR DISCLOSURE FOR THE FOLLOWING DATES: ☐All From: _____ To: _____
Only information obtained during the date range above will be disclosed.

PURPOSE OF DISCLOSURE: (check all that apply)

☐ Coordination of Care
☐ Transfer of Care/New Provider
☐ Guardianship Process
☐ Insurance/Billing/TPO
☐ Personal Records
☐ Legal/Court Hearing
☐ IEP/School
☐ Other: _____
☐ Disability Determination
☐ Confirmation of Service
☐ Workers Compensation

INFORMATION TO BE RELEASED: (check all that apply)

☐ Clinical/Mental Health Progress Notes
☐ Prescription Record
☐ Intake/Closing Summary
☐ Employment Information
☐ Third Party Documentation
☐ Psychiatric Progress Notes
☐ Diagnosis
☐ Treatment Plan/Summary
☐ Letter/Summary of Service
☐ Medical/Dental Information
☐ Case Management Progress Notes
☐ Psychological Evaluation/Assessment
☐ Billing/Financial Records
☐ Completion of External Form
☐ HIV/AIDS Information _____ signer must initial
☐ Substance Abuse and/or Alcohol Treatment Record
☐ Sexual Abuse/Assault Counseling Records
☐ All Records

☐ Other: _____

FORMAT OF RECORDS TO BE RELEASED: (check all that apply)

☐ Paper/Hard Copy ☐ Electronic/Email* _____
email address required

☐ Verbal ☐ Other: _____

*Email address must be verified before any information can be emailed. All information sent via email will go through our secure email system.

FEES*: Fees are authorized annually by the state law. Fee must be paid before records can be released. Record fees will be billed as follows:

Clients and Service Providers:
* Cash or credit only

Paper Copies: Maryland: 76¢/page
Virginia: 50¢/page for first 50 pages, 25¢ page at 51 or more pages
Both: Copies totaling under 20 pages are free
Electronic Copies: Cost of Labor: $40/hr

Attorneys/Insurance Companies/Other: Service Fee: $22.88(Maryland) or $10.00 (Virginia) in addition to costs stated above

MINOR CONSENT: Please review the information carefully.
*if applicable

- **MD** – A Minor who is 16 years old or older has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic [Md. Code Ann., Health-Gen. || § 20-104(a)].
- **VA** – A minor who is 14 years old or older is "deemed an adult for the purpose of consenting to…medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance;" and the minor is "also deemed an adult for the purpose of accessing or authorizing disclosure" of those records [Virginia § 54.1-2969, E and 12 VAC 35-115-90].

LEGAL AUTHORITY: Please review the information carefully. If information is missing the request may not be processed.
*if applicable

- If the client lacks capacity to sign, a legally authorized person may sign and date the form.
  » » » Please indicate your legal authority and include documentation of your relationship:
  ☐ Power of Attorney/Health Care Proxy ☐ Legal Guardian or Conservator ☐ Other, specify_____

WBMA, employees, volunteers, and agents have a duty to maintain confidentiality of any protected health information disclosed to them pursuant to this authorization. The client or authorized person may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, by providing written notice to WBMA's Compliance Officer. Unless otherwise noted below, this authorization will expire 12 moths from the date of consent. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and/or state confidentiality laws, including HIPAA. WBMA may not condition treatment, payment, enrollment, or eligibility for services on whether the client signs this authorization. The client has a right to signed copy of this authorization.

CONSENT IS GRANTED: (check only one)

☐ One-Time ☐ One-Year ☐ Other, specify _____
Cannot exceed 1 year

Signature of Client or Authorized Representative: _____ Date Signed: _____

Printed Name of Person Signing (if not the client): _____ Relationship to Client: _____