

PSYCH ASSOCIATES OF MD, L.L.C.

**AUTHORIZATION TO DISCLOSE RECORDS
To Primary Care Physician**

I request and give permission to Psych Associates of Maryland, LLC, to send a report to my Primary Care Physician and to communicate with my PCP as needed.

Patient Name _____ Date of Birth ____/____/____

Primary Care Doctor (name): _____

Primary Care Site: _____

Address: _____

This consent will be in effect until I revoke by written notice.

This consent will be in effect until: _____
(specification of date, event or condition upon which this consent expires)

Signature (Patient/Parent/Legal Guardian) _____

Date ____/____/____ Witness _____
