I hereby authorize: ____

Fax: ____

To release copies of all medical records compiled during office visits and/or hospital admissions.

Patient: _____________________________________

Date of Birth: _______________________________

Release medical records to:

Potomac Psychiatry
5920 Hubbard Drive
Rockville, MD 20852

Fax (301) 816-0907

This authorization may be revoked by me at any time in writing. Except to the extent that action has been taken in reliance on the information identified above, and for the purpose specified. This signature is good for one year.

_________________________________ Signature

_________________________________ Date

Confidential

This communication, including attachments, is for the exclusive use of the person or entity to which it is addressed and may contain confidential information. If you receive this in error please contact us at the below listed number.