AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

I,____,

Date of Birth: __________________________ Social Security Number: ____________________,

hereby authorize:

Saadia Alizai-Cowan, M.D.
5530 Wisconsin Avenue, Ste 965
Chevy Chase, MD 20815
Phone: (202) 420-8311
Fax: (202) 354-5074

to release and to obtain the following information from my mental health or medical records:

history, evaluations, examinations, studies, diagnoses, formulations, and treatments.

to and from the following individual(s)/agent(s):

____

____

In authorizing this release of information, I understand it will be used solely for the purpose of:

evaluation, coordination/determination of care and/or treatment planning, both now and in the future.

I understand that I have a right to meet with my clinician to inspect my record of mental health information. I further understand that this information cannot be re-disclosed without my expressed authorization and that the law requires this notice.

This authorization releases Dr. Alizai-Cowan from any and all legal liability that may arise as a result of her compliance with my request. This consent is subject to revocation at any time except that action has been taken in reliance thereon.

My signature below attests to the fact that I have read this form, understand its content and request that the above information be released as specified.

____ ____________________
Signature of Patient/Guardian Date