AUTHORIZATION FOR RELEASE OF INFORMATION

Re: _____
Your Name

I, and/or We, the undersigned, hereby give permission to Carol A. Deel & Associates to disclose information to and receive information from the following regarding any findings and results of any medical, mental health treatment or evaluation, discharge summary or other information concerning me, and/or us, and/or child:

_____

_____

_____

I, and/or we, the undersigned, agree to hold Carol A. Deel & Associates free and harmless from all responsibility and liability concerning the release of this information; and waive on behalf of myself, and/or ourselves, and any other persons relating to the disclosure of confidential and/or privileged information.

Signed:_____

Date:_____

I/We agree to refrain from and protect against disclosure of the requested information which is not authorized by further consent of the patient.

Witness:_____

Date:_____

101 South Main Street Suite 307 Bel Air, Maryland 21014 410-879-2470 cadeel@gmail.com