7500 Greenway Center Drive #940, Greenbelt MD 20770
Phone: 301-718-1082   Fax: 301-718-1084

Consent to Release Information

To:________________________ PH:________________________Fax:_____________________
To:________________________ PH:________________________Fax:_____________________
To:________________________ PH:________________________Fax:_____________________
To:________________________ PH:________________________Fax:_____________________

I,_________________________(patient/client), address_________________________________,
D.O.B_____________, last four digits of SS#__________, authorize hereby request that you release the following information to enhance my assessment, treatment and coordination of service to: Dr. Netsere Tesfayohannes and Associates at 7300 Hanover Drive, Suite 204, Greenbelt, MD 20770.

____Medical Assessment
____Diagnosis
____Psychosocial Evaluation
____Psychological Evaluation
____Psychiatric Evaluation
____Treatment Plan/ Summary
____Medication Management Information
____Toxicology/ Lab Reports
____Discharge/ Transfer Summary
____Treatment Progress
____Radiology Reports
____Other:____

Please fax six month pharmacy profile A.S.A.P to 301-718-1084. Patient is currently being seen in this office.

Please do not send the entire medical record, just a summary of the pertinent medical information regarding the current condition.

____I understand I have the right to revoke this authorization writing, at any time.
____I understand this consent expires one year from the date signed below unless indicated otherwise.
____I have received a copy of the consent form.

____   _______________
Signature of Patient/ Client   Date

____   _______________
Signature of Staff Witness   Date

_______Check here if the patient/ client refuses to sign consent.