



**Authorization to Release or Request Healthcare Information**

**Patient Name:** \_\_\_\_\_ **Patient Date of Birth:** \_\_\_\_\_

I, \_\_\_\_\_, hereby request and authorize Gladstone Psychiatry and Wellness to release or  
(name of person signing release)

**request healthcare information of the above-named patient to the following person/organization:**

**Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_  
(name of person/organization)

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**This request and authorization applies to:**

- Any and all healthcare information
- Specific healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_
- Other: \_\_\_\_\_

**Please choose the Gladstone Psychiatry and Wellness office location for which this release is intended:**

- Mt. Washington:** 1501 Sulgrave Avenue, Suite 200, Baltimore, MD 21209  
Phone: 443-708-5856 ● Fax: 667-212-5095
- Hunt Valley:** 11350 McCormick Rd., Building III, Suite 600, Hunt Valley, MD 21031  
Phone: 443-708-5856 ● Fax: 443-353-5701
- Columbia:** 9841 Broken Land Parkway, Suite 211, Columbia, MD 21046  
Phone: 443-708-5856 ● Fax: 240-708-4153
- Bethesda:** 4416 East West Highway, Suite 310, Bethesda, MD 20814  
Phone: 443-708-5856 ● Fax: 240-396-6485

By signing this form, you are authorizing the release of any pertinent healthcare information and records regarding drug, alcohol, or mental health treatment to the person/entity listed above. This release is valid for up to 180 days after discharge from Gladstone Psychiatry and Wellness.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_