Gladstone
Psychiatry and Wellness

Authorization to Release or Request Healthcare Information
(Primary Care Physician)

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:** _____Primary Care Physician_____
(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:** _____