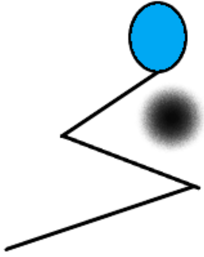

ZenBees Psychiatry and Wellness Services, LLC.
180 Thomas Johnson Drive, #100
Frederick, MD 21702
Phone: 410-693-7401
Fax: 534-429-4341
Email: Zb@zenbeespsychiatry.com

Authorization for Release/Exchange Confidential Information

**Please enter n/a for any non-applicable fields*

Patient ______________________ Date of Birth ____________________

I, (print name of patient or guardian/parents) _______________________________________
authorize ZenBees Psychiatry and Wellness Services, LLC. (select an option below and enter designated person/place full name/address, phone number)

to release :________________

obtain from:_____________________

exchange information with: ________________

the following information pertaining to myself:

__________psychiatric evaluation/medication history

__________labs

_________ All psychiatric history records

__________other (specify)
____

For the purpose of:

__________Evaluation/assessment

__________Coordination of Care/treatment efforts

__________Other (specify) ______________________________

Conditions: ZenBees Psychiatry and Wellness Services, LLC. may not condition your right to receive health care services from us upon signing this authorization. However, if the treatment to be provided is for research purpose, your failure to sign this authorization will prevent us from providing such treatment.

Further Uses and Disclosures: When we use or disclose your health information as you have instructed us in this authorization, we do not have the ability to monitor whether your health

information may be further used or disclosed by such parties. In such situation, your disclosed health information may no longer be protected by Federal and State privacy laws.

Expiration: The consent will automatically expire one (1) year after the date of my signature as it appears below, or on the earlier date, condition or event:

Revocation: I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time in writing (except to the extent that the information has already been released). Provided written notice can be send via patient portal, certified mail, hand delivery to the following address:

ZenBees Psychiatry and Wellness Services, LLC.
180 Thomas Johnson Drive, #100
Frederick, MD 21702

When your revocation request has been received, we will immediately stop using and disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and discloses we made on your behalf pursuant to this authorization prior to the time we receive your written revocation.

I, (print name)____________________________ understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan or edibility for benefits will be conditioned upon my authorization of this disclosure.

Printed patient Name: ______________________________

Signature of Patient: __________________________ Date________________

*Signature of Parent/Guardian/Authorized Representative*______________________________

Date ______________________________

*Note: if signed by someone other than the patient, we must have written proof of his/her authority

Signature of Witness _______________________ Date _____________________________