ZenBees Psychiatry and Wellness Services, LLC.
Frederick location: 180 Thomas Johnson Drive, #100, Frederick, MD 21702
Easton location: 7 S Park Street, Easton, MD 21601
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:

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Easton location: 7 S Park Street, Easton, MD 21601

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 _____