CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

Arman Taghizadeh M.D., LLC
2324 West Joppa Road, Suite 220
Lutherville, MD 21093
Phone (410)583-2623 Fax (410) 583-2949

Name: _____ Date of Birth: _____

I request and authorize the exchange of information concerning diagnosis, treatment, intervention, assessment, academic planning, and medical/medication issues for the above named individual **from and to** the individuals listed below, as part of a comprehensive psychiatric evaluation. This authorization is signed with the express understanding that information shall not be used for any purpose other than specified, shall be maintained in a confidential manner, and shall not be disclosed by the recipient of this information to any other persons, groups, or organizations without specific written permission.

Name: _____
Relationship: _____
Organization:_____
Phone Number: _____

Name: _____
Relationship: _____
Organization:_____
Phone Number: _____

Name: _____
Relationship: _____
Organization:_____
Phone Number: _____

Name: _____
Relationship: _____
Organization:_____
Phone Number: _____

Patient Name: _____ Date: _____

Guardian/Parent Signature: _____ Date: _____

This consent will expire one year from date above, unless otherwise noted.