BETHESDA PSYCHIATRY
Pavan Segal, M.D.

ADULT RELEASE OF INFORMATION FORM

I,_____, hereby authorize Dr. Segal to release information pertaining to my diagnosis and treatment to the following provider/individual(s)/entity:

1) _____

2) _____

3) _____

Information to be used for the purpose of:

☐ Treatment Care and Coordination

☐ Other (ex. billing)

I understand that this authorization shall remain valid from the date of my signature below and indefinitely thereafter (or sooner if specified) ending on:

☐ I have been informed that I may revoke this authorization by written communication with Dr. Segal at any time.

☐ I certify that this form has been fully explained to me and that I understand its contents.

_____
Patient Signature

301-615-4270
7910 Woodmont Ave. Suite 1101, Bethesda, MD 20814
BethesdaPsychiatryLLC.com