AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION
DISTRICT OF COLUMBIA MENTAL HEALTH INFORMATION ACT

I,_____,

Date of Birth: _____ Social Security Number: _____,

hereby authorize:

Saadia Alizai-Cowan, M.D.
1201 Connecticut Avenue, NW, Suite 710
Washington, DC 20036
Phone: (202) 420-8311
Fax: (202) 354-5074

to release and to obtain the following information from my mental health or medical records:

history, evaluations, examinations, studies, diagnoses, formulations, and treatments .

to and from the following individual(s)/agent(s):

_____

_____

In authorizing this release of information, I understand it will be used solely for the purpose of:

evaluation, coordination/determination of care and/or treatment planning, both now and in the future.

I understand that I have a right to meet with my clinician to inspect my record of mental health information. I further understand that this information cannot be re-disclosed without my expressed authorization and that the law requires this notice:

The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization by the client or as provided in Titles III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.

This authorization releases Dr. Alizai-Cowan from any and all legal liability that may arise as a result of her compliance with my request. This consent is subject to revocation at any time except that action has been taken in reliance thereon.

My signature below attests to the fact that I have read this form, understand its content and request that the above information be released as specified.

_____ _____
Signature of Patient/Guardian Date