Safiyyah Abdul-Rahman, M.D
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Tel: 443-621-0391
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RELEASE OF INFORMATION: PSYCHOTHERAPIST

I, _____hereby authorize Dr. Rahman
(Please print your name)

to have the following communication with _____.
(Please Print Psychotherapist's Name)

Please check ALL that apply:

_____ Dr. Rahman may release any applicable information to my Psychotherapist for the purpose of continuity of care.

_____ Dr. Rahman may release only medication information to my Psychotherapist for the purpose of continuity of care.

_____ Dr. Rahman may receive any applicable information from my Psychotherapist for the purpose of continuity of care

_____ Dr. Rahman MAY NOT release information to my Psychotherapist.

This authorization will expire one year from the date it is signed. If you would prefer another date, please indicate the date here _____.

_____Date_____
(Please sign)

Psychotherapist's Name, Address and Phone Number

_____
_____
_____
_____