AMERICAN
PSYCHIATRIC GROUP

Permission to communicate

☐ By checking this box, I am revoking all previous Permission to Communicate forms.

Patient Name: _____ **Date of Birth:** _____

I authorize American Psychiatric Group to share my protected health information with family members or others as designated by me below. This permission is NOT an authorization to release medical records, or a consent to treatment.

This permission also authorizes American Psychiatric Group to communicate with the authorized persons by phone (including voice messages), in person, or by other means acceptable to American Psychiatric Group.

Name:	
Phone Number:	**Relationship to Patient:**
Name:	
Phone Number:	**Relationship to Patient:**
Name:	
Phone Number:	**Relationship to Patient:**

I understand that I am under no obligation to provide American Psychiatric Group with this Permission to Communicate, and that American Psychiatric Group Providers will not condition treatment, payment, or enrollment/eligibility for benefits on my decision to provide or not provide this form. I understand that I may revoke this Permission if I so choose. I can revoke this Permission either by completing a new Permission to Communicate form and indicating my revocation on the form, or by notifying American Psychiatric Group Physicians in writing of my revocation. Communications should be sent to: 17 E Franklin St Baltimore, MD 21202.

NOT EFFECTIVE UNLESS SIGNED AND DATED

Signature of Patient: _____ **Date:** _____

Signature of Guardian (if applicable) _____ **Date:** _____