THE CENTER FOR MENTAL HEALTH, INC.

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Patient Name: _____

Date of Birth _____ **Last Four Digits of Social Security #** _____

I hereby request that the bankruptcy estate of The Center for Mental Health send the above-named patient's records to:

Name: _____

Address: _____

_____

Telephone: _____ **Fax:** _____

I make this request as [check one box]:

☐ **the patient;**

☐ **a family member or representative;**

☐ **insurance carrier that is permitted under applicable law to submit this claim for patient records.**

Print Name: _____

Print Address: _____

Telephone: _____

Return to:
Louise Marada
c/o Stinson Morrison Hecker LLP
1150 18th Street, NW, Suite 800
Washington, DC 20036
Or Fax to: 202-785-9163