CORRESPONDENCE REQUEST FORM

Please fill out all the following information.
A separate form must be filled for each person/organization.

Today's Date: _____

Your Name: _____ Date of Birth: _____

I authorize Columbia Treatment Center to release information to, and to obtain information from the following person or organization:

Recipient's Name: _____

Recipient's Phone: _____

Recipient's Email: _____

The recipient is my (check one of the following):

☐ Attorney ☐ Probation Officer ☐ Counselor ☐ Physician ☐ Parent ☐ Spouse

☐ Other: _____

Purpose of Letter (Check One): ☐ Progress Letter ☐ Completion Letter

Date Needed: _____

☐ No charge (5 or more Business Days from request)
☐ $50 Fee (1-4 Business Days)
☐ $75 Fee (Same Day)

Signed by: _____ _____
Signature of Patient or Legal Guardian Date

This authorization will be valid for one year unless I otherwise specify.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Columbia Treatment Center, LLC DBA
Columbia Treatment Center
5570 Sterrett Place, Suite 205, Columbia, MD 21044
Tele: 410.730.1333 Fax: 410.730.1559 Email: ctc@columbia-treatment.com