MEDICAL INFORMATION RELEASE
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

The undersigned hereby authorizes and requests:

____

(Name of Physician or Hospital)

Of this address:____

____

Physician or Hospital Phone Number:____

To Provide:

Carroll Family Medicine, LLC.
Peter G. Uggowitzer, M.D.
814 Houcksville Road
Hampstead, Maryland 21074
Phone # - 410-239-0406 Fax # - 410-239-0407

With a copy of the medical records of the below referenced patient/recipient. This authorization is valid for:

☐ Any and all information related to past and present medical histories, diagnoses and treatments.

☐ The medical records concerning the period from:

________________________ to______________________

I understand that the medical records to be released may contain information related to HIV status, AIDS, sexually transmitted diseases, alcohol or drug use, or mental health services, and I hereby authorize the release of this information, unless I have checked this box. ☐

I understand that this authorization will automatically expire 1 year from the date signed and that I may cancel it any time, unless the request has already been carried out, in whole or in part.

Patient's Name:______________________________ **Date of Birth:**____________________

Patient's Address:______________________________ **Social Security #:**____________________

______________________________ **Signature:**____________________

Patient's Phone #:______________________________ **Witness:**____________________

Date:____________________