

**MEDICAL INFORMATION RELEASE
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

The undersigned hereby authorizes and requests:

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

To provide: _____

(Name of Physician or Hospital)

Of this address: _____

Phone Number: _____

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: _____ **Patient's Phone #:** _____

Signature: _____

Witness: _____ **Date:** _____