MERIDIAN PRIMARY CARE
Carlo E. Gopez, M.D. Helene Lee, M.D.
Jennifer Benner, FNP-C
115 North Bridge Street, Elkton, MD 21921
(Tel) 410-398-3041 (Fax) 410-392-6853

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

By signing this form, I, _____Date of birth:_____/_____/_____
PATIENT NAME (printed)

AUTHORIZE : _____AT
(Prior Provider / Specialist / Hospital / Entity)

ADDRESS:_____ CITY:_____STATE:_____ZIP:_____

PHONE: (_____) _____ -- _____ FAX: (_____) _____ --_____

to release confidential health information about me, by releasing a copy of my medical records or a summary of my protected health information, TO MERIDIAN PRIMARY CARE (Dr. Gopez/Dr. Lee/ NP Benner) at the above contact information. I understand that I am responsible for any fees for copying and mailing the information requested.

The information you may release subject to this release form is as follows:

☐ **Complete Records** ☐ Other:_____

****

SPECIAL AUTHORIZATION FOR DRUG / ALCOHOL/ PSYCHIATRIC TREATMENT RECORDS:

☐ I specifically authorize the disclosure of information pertaining to drug / alcohol /and or psychiatric treatment _____(INITIALS)

****

Or

☐ Medication Records	☐ Operative Reports	☐ History and Physical
☐ Hospital Records	☐ Pathology / Cytology Reports	☐ Specific Dates:
☐ Lab reports	☐ Radiology Reports	___/___/____through___/___/____

The purpose of this release of information is for continuity of care (OR other: _____)

PATIENT NAME (Printed):_____DATE OF BIRTH:_____/____/_____

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PREFERRED CONTACT PHONE NUMBER: (_____) _____ -- _____

SIGNATURE:_____DATE:_____
(Patient or Personal representative / Parent if patient is a minor / Guardian)

NAME OF REPRESENTATIVE / PARENT / GUARDIAN (printed):_____

DESCRIPTION OF REPRESENTATIVE'S AUTHORITY:_____

Rev 2/1/20