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|  | 10910 Little Patuxent Parkway, Suite 200 Columbia, MD 21044  Phone: (410) 997-2770  Fax: (410) 997-0066  www.primarycare-doctor.com |

# **AUTHORIZATION TO OBTAIN MEDICAL INFORMATION**

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| PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  MAIDEN OR OTHER NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **I request and authorize the following Physician/Facility to release medical records to EC Primary Care Physicians, P.A. at the address listed below:**  NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | OFFICE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   **PLEASE MAIL RECORDS EXCEEDING MORE THAN FIVE PAGES TO THE ADDRESS INDICATED ABOVE, OTHERWISE, FAX RECORDS TO THE NUMBER ABOVE.** |

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| **Please specify the dates and type of information to disclose:**   |  |  | | --- | --- | | ☐ All Medical Records  ☐ Medical Records From: \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_   ☐ Immunization Records  ☐ Lab Reports  ☐ AIDS/HIV  ☐ Diagnostic Imaging (x-rays, ultrasounds, etc)  ☐ Genetic Testing | ☐ Consultation Notes ☐ Substance/ Drug Abuse ☐ Psychology Conditions ☐ Demographic Information  ☐ Progress Notes ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| *I accept the terms and conditions to authorize E.C. Primary Care Physicians, P.A. to obtain my medical records from another Physician/Facility.*  Patient or Patient Guardian Signature (PLEASE PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient or Patient Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
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