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

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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

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| **I request and authorize EC Primary Care Physicians, P.A. to *RELEASE* medical records to the following Physician/Facility:**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| OFFICE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

REASON FOR DISCLOSURE OF RECORDS: ☐ Change of Insurance or Physician ☐ School ☐ Continuation of Care ☐ Legal☐ Consultation ☐ Personal Use |

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|  **Please specify the dates and type of information to disclose:**

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|  ☐ 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 release my medical records to another Physician/Facility.*Patient or Patient Guardian Signature (PLEASE PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient or Patient Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
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