Authorization To Release Medical Information

Patient:____

Patient Address:____

Street, City, State, Zip Code

Patient Date of Birth:____

Name of Hospital or Physician's Office:____

Office Address/Phone/Fax:____

I hereby authorized the above Hospital/Physician to disclose:

___ All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for any conditions, including (but not limited to) psychological or psychiatric impairment, substance abuse, alcoholism, Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS).

Or,

___ Only medical records from _________________________ to ____________________________

TO: METEROPOLITAN ELITE FAMILY PRACTICE, LLC

Linda J. McGee, MD

3450 Forte Mead Road Suite 109

Laurel, MD 20724 Tel301-317-8660 Fax301-317-8663

I understand that I am entitled to revoke my consent where applicable.

Signature____ Date __________________

Expires in 6 months