AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

From:
Takoma Park Gynecology, LLC
7050 Carroll Ave., Suite 201
Takoma Park, MD 20912
Phone: 301-960-1155
Fax: 301-960-0097

I, _____ hereby voluntarily authorize the disclosure of information from my health record.
(name of patient)

Patient Name:_____ Medical Record Number:_____

Address:_____ Date of Birth:_____

The information is to be provided to:

Name of person/organization/facility:_____

Address:_____

Phone Number:_____

Information Requested:

☐ Healthcare information relative to the following treatment, condition, or dates:

_____

☐ Complete medical record.

☐ I authorized the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Purpose of release:_____

Patient Signature:_____

Date:_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED