8186 Lark Brown Road Elkridge MD 21075
10981 Johns Hopkins Road Laurel MD 20723
(410) 730-3399

AUTHORIZATION FORM TO COMMUNICATE MEDICAL AND/OR FINANCIAL INFORMATION TO OTHERS

I, ____ authorize the following individuals:
(PRINT PATIENT NAME)

__________________________________(PRINT) Relationship:________________________________

__________________________________(PRINT) Relationship:________________________________

__________________________________(PRINT) Relationship:________________________________

__________________________________(PRINT) Relationship:________________________________

to perform the following activities on my behalf with any Physician, Nurse Practitioner or Staff Member at Centennial Medical Group.

Please check those that you are authorizing:

☐ **FULL ACCESS** to Medical, Financial & Scheduling information

OR

☐ Make and cancel Appointments on my behalf

☐ Request and discuss medical information (including medications)

☐ Handle and discuss financial records and information

☐ Deliver and pick up information to/from CMG on my behalf

☐ Other (please describe):____

____

____

This authorization is effective from: ________________ to __________________ **OR** **Indefinitely** (cicle).

____________________________________ ______________________ ________________
Patient Signature Date of Birth Today's Date

UPDATED 10/23/2019 GD