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

MEDICAL RECORD RELEASE OF INFORMATION AUTHORIZATION

Please complete all fields below. Missing information will result in delay of medical record delivery.

PATIENT INFORMATION

Name: ____ Date of Birth: __________________________

Address: _______________________________ City: ____________________ State: _____ Zip: ____________

Phone #: ______________________________________ Cell #: _____________________________________

INFORMATION FROM	INFORMATION TO
Doctor/Facility Name: ___________________________ Address: ____________________________________ City: ________________ State: _______ Zip: _________ Phone: _____________________________________ Fax: _______________________________________	Centennial Medical Group 8186 Lark Brown Road Suites 201-202 Elkridge, MD 21075 Phone: (410) 730-3399 Fax: (443) 478-4729

MEDICAL RECORD SPECIFICATIONS

☐ All Records ☐ Date of Service: Start Date: _____________ End Date: _____________

Specific Information: ____

PURPOSE OF DISCLOSURE

☐ Transfer of Care ☐ Other: ____

LEGAL REQUIREMENTS

You must provide your initials to each of the following if requesting.

My evaluation, diagnosis, and/or treatment relating to the conditions listed below may be released to the requestor identified above for the following types of records unless otherwise indicated:

_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)

_____ Psychiatric care and/or psychological assessment

_____ Treatment for alcohol and/or substance abuse

_____ Mental health treatment

Note: Failure to initial above will automatically imply a declination to obtain/disclose

AGREEMENT

I understand that:

- I have the right to revoke this authorization at any time;
- My revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure;
- The revocation does not apply to information already released in response to this authorization;
- Any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law;
- I need not sign this authorization to assure continued treatment;
- I may inspect and/or copy the information to be disclosed;
- Authorizing this disclosure is voluntary;
- If I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization;
- There may be a fee for this service.

Requests cannot be processed without proper authorization. Minors must have a parent signature. Individuals requesting records on deceased or adult patients may be asked to provide the required Power of Attorney or other supporting legal documents.

_________________________________ _________________________________ ____________

Signature of Patient or Authorized Representative Printed Name of Authorized Representative Date