_________________________________________
Patient's Full Name – Please Print

_______________________________________
Patient's Date of Birth

__________________________________________
Street Address

_______________________________________
Social Security Number

__________________________________________
City, State and Zip Code

_______________________________________
Beginning Date

__________________________________________
Contact phone number

_______________________________________
Date of Request

I do _____ I do NOT_________
authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RELEASE INFORMATION TO:

CAL ARUNDEL FAMILY MEDICINE, LLC
ATTN: MEDICAL RECORDS
32 COX ROAD
HUNTINGTOWN, MD 20639

PURPOSE OF DISCLOSURE:

Referral to Specialist _________Legal Investigation __________Other (Please Specify)__________________
Insurance _____ Workers Comp _____ Disability Determination______Personal Copy _____
Changing Doctors _________ Continuing Care __________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
At the request of the individual, I _______________________________________________, do hereby authorize
________________________ __________________________________________________ to release
records to include:

Discharge Summary _______History and Physical ______Progress Reports _________
Operative Reports________ Pathology Reports_________ Laboratory Reports________
Radiology Reports ECG/Cardiac Cath __________ Emergency Room Reports Other (Please specify)______________________________________________________________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized/furnished may not condition its treatment of me on whether or not I sign the authorization.

_________________________________________________________
Signature of Individual, Guardian or Personal Representative of Patient's Estate