ROCKVILLE
INTERNAL
MEDICINE GROUP

Rockville Internal Medicine Group
1201 Seven Locks Road Suite 111
Rockville, MD 20854
Phone: 301-762-5020, Fax: 301-294-7569

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ (Print **patient's** full name)

_____ Birth date (Mo/Day/Yr)

_____ (Street address)

_____ Social Security Number

_____ (City, state, zip code)

_____ Phone (Home)

At the request of the individual, I _____, do hereby authorize medical record
(Patient's name)

INFORMATION RELEASED *TO:*

_____
Name of Company/Agency/Facility/Person

_____
Street address

_____
City, state, zip

INFORMATION RELEASED *FROM*:

_____
Name of Company/Agency/Facility/Person

_____
Street address

_____
City, state, zip

_____HISTORY & PHYSICAL
_____PROGRESS NOTES
_____OPERATIVE NOTES
_____LABORATORY REPORTS
_____RADIOLOGY REPORTS
_____EMERGENCY REPOIRTS
_____OTHER_____
_____
_____

***For edelivery, please complete attached form along with this authorization for release of records.*
** If records are not needed within 7-10 business days they will be mailed.

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST
_____LEGAL INVESTIGATION
_____INSURANCE
_____DISABILITY DETERMINATION
_____WORKERS COMP
_____PERSONAL
_____CHANGE OF DOCTOR
OTHER_____

I hereby authorize disclosure of the health information for the above named patient. I 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. 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 it will not effect 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 is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of individual or guardian or Personal Representative of patient's estate **Date**

NOTE: Federal and state laws permit a fee to be charged for the copying of patient records. CiOX Health has been contracted to provide the service of medical records request. CiOX Health can be reached at 1-800-367-1500.