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qualitycaremd.com

## Authorization to Release Healthcare Information

Type into the boxes on your computer, or print and fill in by hand.

Patient Name  DOB

I request and authorize Quality Primary Care Associates to release my healthcare information to:

Practice / Physician's Name

Phone  Fax

Address

City  State  ZIP

**This request and authorization applies to: Choose one (A, B, or C)**

☐ A. All healthcare information

☐ B. Healthcare information relating to the following treatment, condition, or dates:

☐ C. Other:

**Sensitive records** These are left out unless you choose Yes. Please answer both.

I authorize the release of my STD and HIV/AIDS results, whether negative or positive. ☐ Yes ☐ No

I authorize the release of records regarding drug, alcohol, or mental health treatment. ☐ Yes ☐ No

Sexually Transmitted Diseases (STD) include, but are not limited to, herpes, herpes simplex, human papillomavirus (HPV), genital warts, condyloma, chlamydia, nonspecific urethritis, syphilis, lymphogranuloma venereum, gonorrhea, and HIV/AIDS.

Signature  Date

If the patient is younger than 18, a parent or guardian must sign. This authorization expires one year after the date signed and may be revoked by the patient in writing at any time.

### How to return this form

Email it to [qpca@qualitycaremd.com](mailto:qpca@qualitycaremd.com), fax it to 833-989-2090, or bring it to any of our offices.

### QUALITY PRIMARY CARE ASSOCIATES

Rockville: 50 West Edmonston Drive, Suite 404, Rockville, MD 20852

Gaithersburg: 818 West Diamond Avenue, Unit 130, Gaithersburg, MD 20878

Columbia / Elkridge: Chartwell Medical Center, 8186 Lark Brown Road, Suite 201, Elkridge, MD 21075