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qualitycaremd.com

Authorization to Release Healthcare Information

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:

☐ All healthcare information

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

☐ Other: _____

☐ I authorize the release of my STD and HIV/AIDS results, whether negative or positive.

☐ I authorize the release of records regarding drug, alcohol, or mental health treatment.

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.

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