QUALITY PRIMARY CARE ASSOCIATES

Phone 301-762-7723
Fax 301-762-3721
qualitycaremd.com

Authorization to Request Healthcare Information

Patient Name _____ DOB _____

I authorize the practice / physician below to release my healthcare information to Quality Primary Care Associates:

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.