

GREATER ANNAPOLIS



MEDICAL GROUP

Internal Medicine

Lisa A. DiMarsio, M.D.

Andrew G. Gordon, M.D.

John D. Jackson, M.D.

Robert A. Miller, M.D.

Kevin J. O'Keefe, M.D.

Birgitta E. Miller, M.D.

Mail Pick up

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to release my protected health information for the purposes of treatment, payment and health care operations to _____

Patient Name: _____ DOB ____/____/____ SS# ____/____/____

Information requested:

____ History and Physical

____ Immunization Records

____ Progress/Clinical

____ Lab or X-Ray Data

____ Diagnostic Studies

____ Problem List/Clinical Summary

____ Current Medication List

____ Other(Specify) _____

Records from _____ to _____

for the purpose of _____

If the requested portion of the record contains information pertaining to drug or alcohol related diagnosis and treatment, or contains HIV related information, or information about mental health disorders, you must specifically consent to the release of such information by signing one or more of the following:

I understand that if my records contain information concerning drug or alcohol related diagnosis and treatment, such information will be released pursuant to this consent form.

I understand that if my records contain confidential HIV related information, such information will be released pursuant to this consent form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information that could indicate that a person has been potentially exposed to HIV.

I understand that if my records contain information concerning the diagnosis or treatment of a mental health disorder, such information shall be released pursuant to this consent

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Unless I revoke this authorization to release information shall expire when the information is received or when:

(State date, event, or condition of expiration)

Patient's current address

If the above named person is either under age 16 or has a legally appointed guardian, this release must also be signed by his/her parent or guardian. Proof of guardianship may be required in some cases.

Signature of patient/ date

Signature parent/ guardian/ date

Witness _____