Dunkirk Family Practice
2025 Chaneyville Road, Suite 200, Owings, MD 20736 | Phone: 410-286-3865 | Fax: 410-286-8085 | www.DunkirkFamilyPractice.com

_____ _____
(Print patient's full name) Birthdate (MM/DD/YY)

_____ _____
(Street Address) Social Security Number

_____ _____
(City, State, Zip code) Phone (Home)

At the request of the individual, I _____, do hereby authorize _____to release:
(Patient's Name) (Name of Releasing Company/Practice)

Releasing Company's Address, Phone, and Fax Number: _____
_____

DATES OF RECORDS RELEASE (please select one): ( ) Most recent visit ( ) Last 3 years ( ) All visits

_____DISCHARGE SUMMARY _____PATHOLOGY REPORTS _____HISTORY & PHYSICAL
_____EMERGENCY REPORTS _____LABORATORY REPORTS _____PROGRESS NOTES
_____RADIOLOGY REPORTS _____OPERATIVE NOTES _____ECG/EEG/CARDIC CATH
_____OTHER_____
_____
_____

_____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP
_____CHANGE OF DOCTOR _____LEGAL INVESTIGATION
_____DISABILITY DETERMINATION _____PERSONAL _____CONTINUING CARE
_____OTHER

*Please provide the current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named company. This authorization is valid for twelve (12) months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect 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 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: <u>There will be a charge for a personal copy or the permanent transfer of your records.</u>

ATTENTION! ANY RECORDS OVER THIRTY (30) PAGES SHOULD BE SENT VIA DIRECT ADDRESS (ENCRYPTED EMAIL) OR US POSTAL SERVICE.