SIMMONDS, MARTIN & HELMBRECHT OF ADVANTIA

Suite 410	Suite H	Suite 200	Suite 400	Suite 600 B	Suite 300
555 Quince Orchard Rd.	77 Thomas Johnson Dr.	26005 Ridge Rd.	11921 Rockville Pike	22616 Gateway Center Dr.	1738 Elton Rd.
Gaithersburg, MD 20878	Frederick, MD 21702	Damascus, MD 20872	Rockville, MD 20852	Clarksburg, MD 20871	Silver Spring, MD 20903

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

RELEASE TO: _____

PHONE: _____ FAX: _____

RELEASE FROM: _____

PHONE: _____ FAX: _____

PATIENT NAME: _____

DOB: _____ PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

I, _____ AUTHORIZE AND REQUEST YOU TO PROVIDE A COPY OF:

_____ ALL INFORMATION RELATED TO MY PAST AND PRESENT MEDICAL HISTORY DIAGNOSIS AND TREATMENTS.

_____ MEDICAL RECORDS FROM SERVICE DATES: _____ TO _____

_____SPECIFIC RECORDS OR TESTS _____

*PLEASE STATE THE REASONS FOR THE REQUEST OR TRANSFER:

I understand the medical records to be released may contain information related to HIV status, AIDS, sexually transmitted disease, alcohol, drug abuse and mental health services, I also understand that under Maryland law there may be a charge for preparing and copying all or any medical records. This authorization for discloser is valid for a period of one year or until (date) _____, whichever is sooner, and may be withdrawn by me at any time except during action taken in response herein.

PLEASE ALLOW 2 TO 3 WEEKS TURN AROUND TIME.
THE REQUEST MUST BE IN WRITING. THERE WILL BE A FEE FOR ALL RECORDS.

SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____