MEDICAL RECORDS DEPARTMENT

Tel: 410.730.1212 Fax: 410.730.2812

web: www.mdneuro.com

MARYLAND NEUROLOGICAL CENTER

Authorization for Release of Medical Information

Patient Name:
DOB:

Release the following information:

___ Entire Medical record

___ Specific dates of treatment: From: _____ to _____

___ Other _____

Please forward copies of requested records to:

Name:		
Address:		
City	**State**	**Zip**

Please check all that apply:

___ This request is being made because I am transferring care to another provider or leaving the area.

___ I authorize for the release of information at the request of the individual

___ I also authorize for the release of information regarding assessment, diagnosis, and treatment of alcohol and/or substance abuse.

___ I also authorize for the release of information regarding diagnosis and/or treatment of AIS or HIV.

___I also authorize for the release of information to the following Individuals:

_____

I understand that I have the right to revoke this authorization, in writing at any time by sending a written notification to **Maryland Neurological Center, Attention Medical Release Correspondent,** at 11085 Little Patuxent Parkway, Suite 212, Columbia, MD 21044.

I hereby authorize Maryland Neurological Center to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

PLEASE ALLOW 10-14 BUSINESS DAYS FOR PROCESSING

COPYING OF RECORDS WILL BE SUBJECT TO A SERVICE CHARGE

Patient Signature	Date

FOR OFFICE USE ONLY:

Pick up Date:	**Time**	**Initial**