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** _____