Medical Records Authorization Disclosure Form

Print or Type

Name:____
Last First Middle

SSN:________________ Date of Birth______________ Phone______________

Please give name and address of medical facility you are authorizing your medical records released from

Physician/Clinic: Clear Minds Family and Mental Health

Address 11140 Rockville Pike, Suite 590A, Rockville, MD 20852

Phone 301-580-4776 Fax________________

I authorize my medical records be released to:

Name:____

Address____

Phone________________________ Fax________________________

Check all records to be released:

- [ ] Mental Health
- [ ] HIV/AIDS Tests/Results
- [ ] Billing
- [ ] Drug/Alcohol use/abuse
- [ ] All Medical Records
- [ ] Other (specify)________________________
- [ ] Labs/Test Results
- [ ] Follow Up Exams

Purpose of records being released:

- [ ] Continuity of Care
- [ ] Legal Claim
- [ ] Personal Copy
- [ ] Disability Claim
- [ ] Insurance Claim
- [ ] Other

This authorization is in effect from _____________ to ____________. Upon conclusion of this time, this authorization is automatically revoked.

I understand that:

- I may refuse to sign this authorization and that any refusal has no impact on receiving treatment
- I can inspect or copy any information disclosed under this agreement
- My signing the document is voluntary
- I can revoke authorization at any time, except to the extent that the practice has has acted upon this authorization and revocation must be in writing
- I can receive a copy of this authorization
- Federal laws will not cover information once it is released

Patient/legal Guardian Signature________________________________ Date______________