3200 Tower Oaks Blvd,
Ste 100
Rockville, MD 20852
Phone # 240-623-0033
Fax # 240-219-2193

Authorization for Release of Medical Records

Patient Information

Name: _____

Address: _____

_____

Date of Birth: _____

Social Security # :_____

Request Release From

Facility: _____

Address: _____

_____

_____

Fax #: _____

I hereby authorize you to release to: **Rockville Surgical Suites, LLC** a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time, Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and this, is no longer protected under privacy rules.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse. I understand that release of psychotherapy notes requires an additional authorization.

_____ _____

Signature Date

_____

Witness

Patient Label