

Annapolis Internal Medicine
116 Defense Highway
Annapolis, Maryland 21401
Ph: (410) 897-9841 Fax: (410)897-9852



Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____
Address: _____ Physician: _____

I request and authorize **ANNAPOLIS INTERNAL MEDICINE** to release healthcare information of the patient named above to:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition or specific dates: _____

All healthcare information

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Medical records records will be processed as soon as possible. However, can take up to thirty days to complete. Requests from patients that are less than twenty five pages will be available for pickup or faxed at no charge. Requests from patients that are more than twenty five pages will be copied to a CD for a flat fee of \$20.00 (this includes fees, postage and handling) Charges for third party companies requesting records will be \$20.00 for the records plus \$22.88 for a preparation fee.

Printed Name: _____

Signature: _____ Date Signed: _____

*****THIS AUTHORIZATION EXPIRES 12 MONTHS AFTER THE DATE IT IS SIGNED*****