Potomac Region Medical Associates

14300 Gallant Fox Lane
Bowie, Maryland 20715
(301) 805-4348

1600K Crystal Square Arcade
Arlington, Virginia 22202
(703) 418-1870

AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION

- **All required areas must be completed or this release will be considered invalid.**
- **Please fill out all sections and**
- **Please specify the type of health information to be forwarded**

PART 1. PATIENT INFORMATION:

Patient Name:		Date of Birth:
Social security number:	Day time phone:	Home phone number:
Address: (Street, City, State, Zip code)		

PART 2. DESTINATION OF RECORDS:

I HEREBY AUTHORIZE (provider/facility)_____ _____to release medical records information concerning the above patient to:

Recipients Name:	Recipients Phone Number:	Fax:
POTOMAC REGION MEDICAL ASSOCIATES	***(703) 418-1870***	***(703) 418-0283***

Recipients Address: (Street, City, State, Zip Code)

1600k Crystal Square Arcade Arlington, Virginia 22202

Part 3. PURPOSE OF RELEASE: **Fees are applicable if the nature of the request is for other than the patient's continuation of care.**

This Authorization to Release Protected Health Information shall expire (12) twelve months after date of signature.

Purpose of Request: ( ) Continuation of care ( ) Personal Use ( ) Work/Employment

( ) Legal ( ) Other_____

Part 4. TYPE OF RECORD BEING REQUESTED

Please note: request normally take 15 business days for processing:

( ) Copies of records of the last (2) two years
( ) Copies of records covering dates from _____ to _____
( ) Laboratory Results (Dates) _____
( ) Pharmacy profile
( ) Radiology results (specify)_____

I authorize the release of photocopies of the following medical record and/or diagnostic radiology results in the possession or control of Fit for Life Medical Center Inc. For the purposes hereof, "Medical records" and radiology results shall include:

- Confidential HIV-Related Information
- Confidential Communicable Disease-Related Information
- Confidential Alcohol or drug abuse treatment information
- Confidential Psychotherapy notes
- Confidential genetic testing results

PATIENT SIGNATURE: (Authorization is valid for (12) twelve months)			DATE:
PARENT/GUARDIAN/POWER OF ATTORNEY:	RELATIONSHIP TO PATIENT	WITNESS:	DATE: