Crystal Medical, LLC
Patient's Authorization to Release Medical Information

I authorize: To release to: Fax#_____

Name of doctor

Name

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

The following information (check all applicable):

☐ All Progress Notes ☐ Lab Reports ☐ X-Ray Reports ☐ EKG

☐ Allergy Records ☐ Immunization Records ☐ Other

SPECIAL AUTHORIZATION (check all applicable and initial): Initials: _____

☐ Sexually Transmitted Disease(s) ☐ HIV/AIDS ☐ Alcohol

☐ Drug Use ☐ Mental Health

Covering the period from _____ to _____

For the purpose of (check all applicable):

☐ Continued Medical Care ☐ Worker's Compensation Claim ☐ Personal

☐ Payment of Insurance Claim ☐ Legal Reason ☐ Other: _____

I understand that this authorization is valid for one year unless revoked by me, and that I can revoke it at any time except to the extent that the requested action has already occurred.

I understand that a reasonable fee may be charged for the duplication of my records, and I accept responsibility for the payment of all charges arising out of this request.

Printed Name Signature Date

Street Address City, State, Zip Code Daytime Phone

This record has been disclosed in accordance with Subtitle 3 of Title 4 of the Health-General Article of the Annotate Code of Maryland. Further disclosure of this record and the information contained herein is prohibited by Subtitle 4-303(b)(5)(ii).