Authorization to Release Medical Information

Patient Information

Name: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

Records to be released FROM: _____

Address: _____

Phone: _____ Fax: _____

Request the following:		**Disclosure Format:**	
○	Full Copy of Patient Records	○	FAX
○	Lab/Radiology/DME Report	○	Patient Pick-Up
○	Immunizations	○	US Mail-Paper
○	Dates: to	○	
○	Other:	○	

Records to be sent TO: Bloom Family Health & Wellness

Address: 770 Old Liberty Rd Ste 3 Eldersburg, MD 21784

Phone: 410-970-8480 Fax: 855-576-5073

As listed below, I understand the following:

1. I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it.
2. The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations.
3. I am entitled to a copy of this document.
4. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits.
5. There may be a charge for the release of these records.
6. This authorization shall expire upon written request to revoke or according to state law.
7. A copy of this authorization is as valid as the original.

_____ _____

Signature of patient (or representative): **Date:**

Witness: _____