AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO DDA

PLEASE READ THE FORM CAREFULLLY AND FILL OUT COMPLETELY

I AUTHORIZE:

_____

Name of Sending Person/ Organization

_____

Street Address, City, State, Zip Code

Information to be released: Any information including the diagnosis and records of any treatment or examination rendered to me.

RECORDS FROM THE TIME PERIOD: _____ to _____.

PURPOSE OR NEED FOR DISCLOSURE: Continuity of medical care

AUTHORIZATION:

- I understand this consent can be revoked in writing at any time. This revocation will not cover disclosures made previously in reliance on this consent.
- This authorization shall expire 90 days from the date noted below.
- I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication

_____ _____

Patient's Name (at time of treatment) Date

_____

Street Address, City, State, Zip Code

_____

Daytime Phone Number(s)

_____ _____

Signature of Patient or Representative, if Minor Date

_____

If Representative, Name and Relationship to Patient

PLEASE FORWARD THE INFORMATION TO THE FOLLOWING OFFICE LOCATION

O 700 Geipe Road, Suite 230 Catonsville, MD 21228 fax: (410) 247-4227

O 10710 Charter Drive, Suite 110 Columbia, MD 21044 fax: (410) 730-0942

My treatment with DDA is with Dr. _____