AUTHORIZATION FOR PLUMTREE FAMILY HEALTH CENTER TO OBTAIN INFORMATION FROM ANOTHER PARTY

PATIENT FULL NAME:		DATE OF BIRTH:	
PREVIOUS NAMES:		SOCIAL SECURITY #:	
PATIENT EMAIL:		PATIENT PHONE #:	

I REQUEST AND AUTHORIZE PLUMTREE FAMILY HEALTH CENTER TO OBTAIN HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE FROM:			
NAME:			
ADDRESS:			
CITY, STATE, ZIP:			
PHONE NUMBER:		FAX NUMBER: (REQ)	
EMAIL ADDRESS:			

THIS REQUEST AND AUTHORIZATION APPLIES TO: (MUST PLACE "X" NEXT TO ONE OPTION)	
	HEALTHCARE INFORMATION RELATED TO THE FOLLOWING TREATMENT, CONDITION OR SPECIFIC DATES ONLY:_____
	ALL HEALTHCARE INFORMATION - # OF YEARS RECORDS _____
	OTHER: _____

YES	**NO**	**PLEASE CHECK YES OR NO FOR EACH ROW**
		I AUTHORIZE THE RELEASE OF MY STD RESULTS, HIV/AIDS TESTING, WHETHER NEGATIVE OR POSITIVE, TO PLUMTREE FAMILY HEALTH CENTER.
		I AUTHORIZE THE RELEASE OF ANY RECORDS REGARDING DRUG, ALCOHOL, OR MENTAL HEALTH TREATMENT TO PLUMTREE FAMILY HEALTH CENTER

PATIENT SIGNATURE:	
DATE SIGNED: (VALID FOR 2 YEARS)	

PLEASE FAX ALL RECORDS TO 410-569-4368
OR
EMAIL RECORDS TO LGRIFFITH@PLUMTREEHEALTH.COM

104 PLUMTREE ROAD, SUITE 102, BEL AIR, MARYLAND 21015 PHONE 410-569-4224 FAX 410-569-4368
WWW.PLUMTREEFAMILY.COM

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