CROSSROADS MEDICAL ASSOCIATES
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print patients full name	**Birth date (Mo/Day/Yr)**
Street address	**Social security number**
City, state, zip code	**Phone (Home)**

At the request of the individual, I _____, do hereby authorize
(patient name)

_____ to release:

____DISCHARGE SUMMARY	____PATHOLOGY REPORTS	____ER REPORTS
____HISTORY & PHYSICAL	____LABORATORY REPORTS	____OTHER_____
____PROGRESS NOTES	____RADIOLOGY REPORTS	_____
____OPERATIVE NOTES	____ECG/EEG/CARDIO CATH	_____

____I do _____I do NOT authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:
Crossroads Medical Associates, LLC
4801 Dorsey Hall Drive STW 201
Ellicott City, MD 21042

PURPOSE OF DISCLOSURE:

____REFERRAL TO SPECIALIST	____INSURANCE	____WORKERS COMP
____LEGAL INVESTIGATION	____DISABILITY DETERMINATION	____PERSONAL

OTHER (SPECIFY)_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate **Date**

Reason for transferring: _____

Please provide current telephone number in the event we need to contact you:_____