PRIMARY MEDICINE, LLC

RELEASE OF HEALTH INFORMATION

Patient: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to disclose my health information to the recipient(s) that I have identified below.

Name:

_____

Address:

_____

_____

Information to be disclosed**:** I authorize the release of the following health information: (Check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- ❑ Healthcare information relating to the following treatment, condition, or dates: _____

_____ _____

Patient Signature Date

(If Individual is unable to sign this Authorization, please complete the information below)

Name of Guardian: _____

Legal Relationship: _____

PRIMARY MEDICINE, LLC

This is a notice of charges for the completion of medical records. There is a $15.00 copying / processing fee and 0.50 per page.

Please complete the attached form.

Upon receipt of payment, records will be released to address specified on the Medical Record Request form no later than 10 business days.

* We accept Cash, Check, Money Orders, and Credit Cards

* Please make all checks payable to Primary Medicine, LLC

* Mail payments to P.O. Box 2510 Laurel, MD 20708