Hampstead Primary Care

4111 Lower Beckleysville Rd
Hampstead, MD 21074
410-374-0808 . 410-374-0045 fax

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: _____
where am I requesting medical records from

Phone #: _____ Fax #: _____

to disclose the following information from the health record of:

Patient Name: _____ Phone #: _____

Address: _____ Date of Birth: _____

_____

Covering the period(s) of healthcare:
From (date) _____ To (date) _____

Information to be disclosed:

- ☐ Last History & Physical
- ☐ Last 3 Laboratory Tests
- ☐ Discharge Summary
- ☐ Last 3 Progress Notes
- ☐ Immunizations
- ☐ X-Rays
- ☐ Other (Please Specify) _____

I understand that this will include information relating to (check if applicable):

- ☐ Infectious Disease
- ☐ Psychiatric Care
- ☐ Treatment for alcohol and/or drug abuse

This information is to be disclosed to:
Stephen Laiken, MD , Amy Yankolonis, CRNP, Susan Harris, CRNP and Amber Johnson, CRNP
for treatment and evaluation.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition.

The facility, it's employees, and providers are hereby released from any legal responsibility or liability for disclosure of the above information to the exent indicated and authorized herein.

If I have questions or change my mind, I know I can call.

Patient Signature: _____ Date: _____