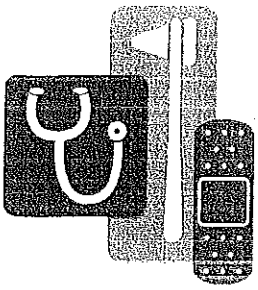

The Primary Care Group of Maryland
Nnaemeka Agajelu MD
Nora Agajelu CRNP
1411 Madison Park Drive Ste1B, Glen Burnie MD 21061
(410) 553 6360 (410) 553 6661 fax

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ SSN: _____

I request and authorize _____ to

release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Witness Signature: _____ Date Signed: _____

Witness Name/Title: _____

THIS AUTHORIZATION EXPIRES **1 YEAR** AFTER IT IS SIGNED.