THE PRIMARY CARE GROUP OF MARYLAND

85 KINDRED WAY, SUITE 101
GLEN BURNIE, MD 21061
OFFICE: (410).553.6360
FAX: (410).553.6661

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: The Primary Care group of maryland

Address: 85 Kindred Way Ste 101

City: Glen Burnie State: MD Zip Code: 21061

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.

Nnaemeka Agajelu, MD
Nora N. Agajelu, CRNP
Anita Mbah, PA-C
Karalee Watts, PA-C