THE PRIMARY CARE GROUP OF MARYLAND

85 KINDRED WAY, SUITE 101

GLEN BURNIE, MD 21061

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Agreement to Release of Information

I _____ give the staff of **The Primary Care Group of Maryland** permission to release my medical health information to _____. I understand this authorization will stay in place until I make the staff aware it is revoked.

_____ _____

Patient Signature Date

_____ _____

Staff Witness Date