HOLY CROSS HEALTH PARTNERS
at Asbury Methodist Village

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

201 Russell Ave, Gaithersburg, MD 20877
Phone: 301 557 2110 Fax: 301 557 2120

Patient Name: _____

Address: _____

Telephone #: _____ Date of Birth: _____

I authorize the following:

Doctor's Name/Hospital/Clinic:

_____

Telephone #: **Fax#:**

to release to **HCHP at AMV** a copy of my medical records for the purpose of my treatment at Holy Cross Hospital Health Center.

I understand that my medical records may include information relating to Sexually transmitted diseases, Acquired immunodeficiency syndrome (AIDS), Human immunodeficiency virus (HIV), Alcohol and drug abuse, or Mental health issues. I authorize the release or disclosure of this information.

If my medical records contain psychotherapy notes, I specifically authorize the release of the psychotherapy notes.

This authorization is valid for up to **12 months from the date of signature** unless a shorter period is listed. Expiration Date or Event: _____
I understand:

1. I have the right to revoke this authorization at any time except to the extent that information has already been released in reliance on this authorization.
2. The information released as a result of this Authorization may be re-disclosed to others.
3. My treatment or payment for treatment cannot be conditioned on my signing this Authorization.

_____

Signature of Patient/Representative Date Relationship to the Patient