

Johnston Family Medicine  
Medical Records Department  
41 Magna Way # 100  
Westminster, MD 21157  
Phone: (410)751-6684 Fax: (410)751-2371

## Consent for Release of Medical Information

I hereby authorize: **Johnston Family Medicine**, to release my medical record information, including dates, history of illness, diagnostic and therapeutic treatment. The medical records to be released may contain medical information pertaining to psychiatric, drug and/or alcohol diagnosis treatment. In addition, I authorize the release of medical records received from other providers.

**NOTE:** The release of medical records received from other providers may be prohibited by those providers. I understand this consent can be written in writing at any time. This withdrawal will not cover releases made previously in reliance on this consent. This authorization expires 90 days from the date below.

The physicians, its employees, offices and medical staff are released from legal responsibility and liability for the release of the information in accordance with this consent.

### \*A fee may be charged for copies of this medical record\*

#### Please print all information:

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone Number \_\_\_\_\_

Covering for the period: \_\_\_\_\_ to \_\_\_\_\_

complete health record  shot records only  other (specify) \_\_\_\_\_

**Send to:** \_\_\_\_\_  
Name of Physician or Hospital

\_\_\_\_\_  
Address City, State and Zip

\_\_\_\_\_  
Phone Number Fax Number

Reason for Transferring \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Representative

Relationship to Patient \_\_\_\_\_