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 _____
Name of Physician or Hospital

_____
Address City, State and Zip

_____
Phone Number Fax Number

to release my medical record information, including dates, history of illness, diagnostic and therapeutic treatment to: **Johnston Family Medicine at 41 Magna Way, Suite #100, Westminster, MD 21157**. 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 I understand this consent can be withdrawn in writing at any time.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.

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) _____

Signature _____ Date _____
Patient or Representative

Relationship to Patient _____