

MEDICAL AND SURGICAL CLINICS OF SOUTHERN MARYLAND

MEDICAL RELEASE FORM

AUTHORIZATION

I hereby authorize you to pay directly to the Medical & Surgical Clinics of Southern Maryland, benefits due me out of indemnity under the terms of my policy issued by my company. For Medicare beneficiaries, I authorize any holders of medical or other information about me to release to the social security administration, its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request payment of medical insurance benefits either to myself or to the party who accepts assignment above. Payment is authorized upon receipt of an itemized statement or claims submission for services rendered to me.

Legal Signature: _____

Date: _____

CONSENT

I hereby consent to treatment and to the release of my medical records or portions thereof for the purpose of continuity of care and/or medical operations. You may refer to Medical Group Management's "Notice of Primacy Practices" for additional information on the uses and disclosures of your personal health information. You may review the "Notice" before signing this consent. The "Notice of Privacy Practices" is posted in each of our medical offices' waiting rooms and is also available as a handout.

You can give specific instructions or request restrictions on uses and disclosures of your personal health information. You must understand, however, that the Family Medical Centers are not required to agree to such request (see details in the "Notice of Privacy Practices"), but if we do, the restrictions you have listed below are binding.

You may revoke this consent at any time; however, you must do so in writing. Such revocation does not affect any use or disclosure that had already occurred consistent with the consent.

Patient's Name: _____
(Print)

Guardian's Name: _____
(Print)

Signature of Patient or Legal Guardian

Relationship to Patient

Witness

Date