15245 Shady Grove Road, Suite 150, Rockville, Maryland 20850
Phone: (301) 869-9776 Fax: (301) 417-4947

AUTHORIZATION TO OBTAIN/RELEASE HEALTHCARE INFORMATION

Please include a telephone number or a fax where you would like us to send the request

Patient's Name: _____ Phone:_____-_____-_____

Previous Name: _____

Date of Birth: _____

I request and authorize _____
(Doctor's Name or Facility Name)

Phone Number: Fax Number:
Phone Number or Fax **(Requests with no number will not be faxed)**

release healthcare information of the patient named above to:

Name: CloseKnit

Address: 15245 Shady Grove Road Suite #150

City: Rockville State: MD Zip Code: 20850

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition or dates: _____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorise the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

This information is intended solely for the named recipient(s). Any unauthorized interception of this information is a breach of federal and state law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action with regards to the contents of the document is strictly prohibited. If you have received this information in error, please notify us to arrange for the return or disposal of the document.

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED OR ON THE SPECIFIED DATE.