La Plata Pediatrics and Women's Health

103 Centennial Street, Ste B
La Plata, MD 20646
Office: 301-934-9111
Fax: 301-934-9333

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____

I request and authorize the release the person(s) or healthcare provider(s) below:

Doctor's Name/Practice: _____
Phone Number: _____
Fax Number:_____
Address:_____
City:_____ State: _____ Zip: _____

To release my personal health and medical information to the following healthcare provider(s):

La Plata Pediatrics and Women's Health
Jamie L Reidy, MSN, CRNP, CPNP, WHNP
Mandy Colegrove, MSN, CRNP, WHNP
Hajr Muhammad , MSN, CRNP, FNP
Christina LiCalzi, MSN, CRNP, FNP
Constance Fox, MSN, CRNP, FNP

This request and authorization applies to:

___ Healthcare information related to the following treatment, condition, or dates:_____

___ All healthcare information

___ Vaccine Record

___ Other:_____

Patient Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED.

Confidentiality Note

The information contained in this fax message is confidential health information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or reproduction of the telecopy is strictly prohibited. If you have received this telecopy in error, please immediately notify us by telephone and return the original fax to us at the address listed above via the United States Postal Service. We will reimburse you for postage cost. Thank you.