# AUTHORIZATION FOR PLUMTREE FAMILY HEALTH CENTER TO OBTAIN INFORMATION FROM ANOTHER PARTY

| | | | |
|---|---|---|---|
| PATIENT FULL NAME: | | DATE OF BIRTH: | |
| PREVIOUS NAMES: | | SOCIAL SECURITY #: | |
| PATIENT EMAIL: | | PATIENT PHONE #: | |

| **I REQUEST AND AUTHORIZE PLUMTREE FAMILY HEALTH CENTER TO OBTAIN HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE FROM:** | | | |
|---|---|---|---|
| NAME: | | | |
| ADDRESS: | | | |
| CITY, STATE, ZIP: | | | |
| PHONE NUMBER: | | FAX NUMBER: (REQ) | |
| EMAIL ADDRESS: | | | |

| **THIS REQUEST AND AUTHORIZATION APPLIES TO: (MUST PLACE "X" NEXT TO ONE OPTION)** | |
|---|---|
| | HEALTHCARE INFORMATION RELATED TO THE FOLLOWING TREATMENT, CONDITION OR SPECIFIC DATES ONLY:_____ |
| | ALL HEALTHCARE INFORMATION - # OF YEARS RECORDS _____ |
| | OTHER: _____ |

| **YES** | **NO** | **PLEASE CHECK YES OR NO FOR EACH ROW** |
|---|---|---|
| | | I AUTHORIZE THE RELEASE OF MY STD RESULTS, HIV/AIDS TESTING, WHETHER NEGATIVE OR POSITIVE, TO PLUMTREE FAMILY HEALTH CENTER. |
| | | I AUTHORIZE THE RELEASE OF ANY RECORDS REGARDING DRUG, ALCOHOL, OR MENTAL HEALTH TREATMENT TO PLUMTREE FAMILY HEALTH CENTER |

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|---|---|
| PATIENT SIGNATURE: | |
| DATE SIGNED: (VALID FOR 2 YEARS) | |

**PLEASE FAX ALL RECORDS TO 410-569-4368**

**OR**

**EMAIL RECORDS TO PLUMTREERECORDS@PLUMTREEHEALTH.COM**

104 PLUMTREE ROAD, SUITE 102, BEL AIR, MARYLAND 21015 PHONE 410-569-4224 FAX 410-569-4368
WWW.PLUMTREEFAMILY.COM