Rockville Concierge Doctors

Aimee Seidman, MD, FACP
Adam Possner, MD

9420 Key West Avenue, Suite 104, Rockville, MD 20850
Phone: 301-545-1811 | Fax: 301-545-1814 | www.RockvilleConciergeDocs.net

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Full Name:____ **Date of Birth:**__________________________

Previous Name:____
(If recently married)

Social Security #:________________________

Patient's Address:

____

____

____

Patient's Phone Number:

Home__________________________________

Cell____________________________________

I request and authorize ____
(name of physician or medical facility)

Address:____

____

Phone:___________________________ **Fax:**____________________________

To release healthcare information of the patient named above to:

Rockville Concierge Doctors
Aimee Seidman, M.D., FACP &
Adam Possner, M.D.
9420 Key West Avenue, Suite 104
Rockville, Maryland 20850

Fax 301-545-1814

- ☐ **All Medical Records**
- ☐ **Clinic Notes (Outpatient)**
- ☐ **Emergency Dept. Notes**
- ☐ **Discharge Summary**
- ☐ **History & Physical**
- ☐ **Progress Notes**
- ☐ **Radiology Reports**
- ☐ **Labs**
- ☐ **Consultations**
- ☐ **Immunization Records**

☐ **Yes**
☐ **No**

I authorize the release of any records regarding drug, alcohol, or mental health treatment to Rockville Concierge Doctors.

☐ **Yes**
☐ **No**

I authorize the release of my STI results (including HIV/AIDS testing), whether negative or positive, to Rockville Concierge Doctors. I understand that I must give specific written permission before disclosure of these test results to anyone.

Patient Signature:____Date_____________________

Printed Name:____

Signature of Authorized Representative:____ Date______________________

Representative's Authority to Act on the Behalf of the Patient:____