Rockville Concierge Doctors

Aimee Seidman, M.D., FACP

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

Authorization To Release Healthcare Information

Patient's Full Name_____ **Date of Birth**_____

Previous Name_____

Patient's Address

Street_____**City**_____**State**_____ **Zip**_____

Phone_____

I request and authorize_____

(Name Of Physician Or Medical Facility)

Street_____**City**_____**State**_____ **Zip**_____

Phone_____ **Fax**_____

To release healthcare information of the patient named above to:

Rockville Concierge Doctors
Aimee Seidman, M.D., FACP
9420 Key West Avenue, Suite 104, Rockville, Maryland, 20850
Fax 301-545-1814 * For questions call 301-545-1811

- ☐ **All Medical Records (Immunizations, History and Physical, Consultations)**
- ☐ **Progress Notes**
- ☐ **Radiology Reports**
- ☐ **Labs**
- ☐ **Hospital Records/Discharge Notes**
- ☐ **Lab Reports**

- ☐ **Yes** I authorize the release of any records regarding drug, alcohol, or mental health treatment to Rockville Concierge Doctors
- ☐ **No**

- ☐ **Yes** 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.
- ☐ **No**

Patient Signature_____ **Date**_____

Printed Name_____
Signature Of Authorized Representative_____

Representative's Authority to Act on Behalf of Patient_____