FIRST MEDICAL ASSOCIATES
YOUR HEALTH, OUR PRIORITY

301-515-2901
866-701-4905
www.DrsFirst.com

AUTHORIZATION TO REQUEST HEALTHCARE INFORMATION

Patient Name: _____ DOB: ___/____/____

I request and authorize **the physician/practice** below to release my healthcare information to First Medical Associates.

Practice/Physician's name: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip code: _____

This request and authorization applies to:

- ☐ All healthcare information
- ☐ Healthcare information relating to the following treatment, condition or dates:
  _____
- ☐ Other: _____
- ☐ I authorize the release of my STD, HIV/AIDS results, whether they are negative or positive, to the person/practice listed above.
- ☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person/practice listed above.

Definition: Sexually Transmitted Diseases (STD) as defined by law, RCW 70.24 et seq, including herpes, herpes simplex, human papillomavirus, wart, genital wart, condyloma, Chlamydia, nonspecific urethritis, syphilis, VDRL, lymphogranuloma venereum, HIV, AIDS & gonorrhea.

Signature: _____ Date: _____

If younger than 18, parent/guardian must sign This authorization expires one year after it is signed and may be revoked by patient at any time.

12800 Middlebrook Rd. Suite 400 Germantown, MD 20874
806 West Diamond Ave Suite 110 Gaithersburg, MD 20878
9601 Blackwell Road Suite 210 Rockville, MD 20850
8600 Snowden River Pkwy Suite 207 Columbia, MD 21045
14300 Gallant Fox Ln, Suite 110 Bowie, MD 20715
9801 Georgia Ave. Suite 229 Silver Spring, MD 20902
1415 S Mountain Rd. Suite 100 Joppa, MD 21085