



Mason-Dixon Mobile Medicine

www.masondixonmed.com

☎240.397.6723 📠833-992-0865

Time for a home visit?



Authorization to Release Health Information

Patient Name _____ DOB ____ / ____ / ____

Patient Phone _____

I hereby authorize the release and disclosure of medical information for the above-named patient to Mason-Dixon Mobile Medicine for the purposes of continuity of care, chronic care management, or transitional care management purposes.

Unless otherwise specified, please release the following information (as applicable):

- a. Office Medical Records (prior 2 years)
- b. Hospital Records (prior 2 years)
 - admission H&P
 - discharge summary
 - specialty consultation reports
- c. Imaging Reports (prior 5 years)
- d. Laboratory Results (prior 18 months)
- e. Specialty Diagnostics Testing Reports (prior 5 years)
- f. Home Health Services (prior 2 years)


Patient/Guardian Signature

Date

Guardian Name (as applicable)

This release form shall expire one (1) year from the date indicated above.




Lakeside Med, LLC
3 Hillcrest Dr., Suite A-202
Frederick, MD 21703-6270



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