RELEASE OF MEDICAL RECORDS

TO: _____

ADDRESS: _____
_____
_____
_____

I HEREBY AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO:

POTOMAC FAMILY PLANNING CENTER
Jackson Place North
966 Hungerford Drive
Suite 24
Rockville, MD 20850
Office (301) 251-9124
Fax (301) 251-8581

Any and all information including the diagnosis and/or records of medical treatment.

Information Requested: _____

Date of Service: _____

Print Name: _____ DOB: _____

Signature: _____ Date: _____