pcim
Primecare Internal Medicine

SPECIALIZING IN DIABETES AND HYPERTENSION
Garfield Samuels, M.D. Internal Medicine

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I hereby authorize and request the *(Medical Office)* _____

Address: _____

_____

Phone: _____ **Fax:** _____

To release copies of the following:

- Complete Medical record — to include laboratory tests, x-ray reports, psychiatric treatment et al.

TO: **Primecare Internal Medicine**
4462 Corporate Lane, Suite 190
Virginia Beach, Virginia 23462
Phone: (757) 518-8823
Fax: (757) 518-8832

This authorization shall remain valid for ninety (90) days. I understand that I may revoke this consent at any time but that my revocation is not effective until delivered in writing to the person whom is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with any original records. The person who received the records to which this consent pertains may not disclose them to anyone else without separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

Patient name (printed) _____ DOB: _____

SSN: _____ Sponsor's SSN if applicable: _____

Signature: _____ Date: _____

Witness: _____ Date: _____