



WHERE WE CARE FOR YOU

URGENT CARE

All locations
(877) 222-4934

Easton
8163 Ocean Gateway
Easton, MD. 21601
Fax: (410) 820-0237

Salisbury
2425 N. Salisbury Blvd.
Salisbury, MD. 21801
Fax: (443) 944-0192

Pocomoke City
1511 Ocean Highway
Pocomoke City, MD.
21851
Fax: (443) 437-7378

West Ocean City
12385 Ocean Gateway
Ocean City, MD. 21842
Fax: (443) 664-6882

OCCUPATIONAL HEALTH

All locations
(877) 222-4934 xt 3001
Fax: (410) 334-3614

**Easton
Salisbury
Pocomoke City
West Ocean City**

Billing
2425 N. Salisbury Blvd.
Salisbury, MD. 21801
Ph: (443) 210-2550
Fax: (410) 334-6352

Administration
2425 N. Salisbury Blvd.
Salisbury, MD. 21801
Ph: (877)222-4934
Fax: (410) 334-6352

CONSENT FOR RELEASE OF INFORMATION (rev 06032015)

I hereby authorize Chesapeake Medical Solutions to release my medical record information, which may include dates, history of illness, diagnostic and therapeutic treatment

Patient Name Date

Patient Street Address City, State, Zip Code

Patient Date of Birth Patient Social Security Number Patient phone #

Disclose my health information to:

Recipient Name

Recipient Street Address City, State Zip Code

Recipient Telephone#

For dates of treatment beginning _____ and ending _____.

Circle all records you would like us to copy

Entire record X-Ray X-Ray Reports Office notes Lab Reports Discharge summaries Billing statement

Other: _____

- I understand there is a charge for copying and handling my request and agree to pay these fees at the time of this request.
- I understand that the charges are in compliance with applicable state guidelines
- I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse. I understand that release of psychotherapy notes requires additional authorization.
- I understand that this consent may be revoked in writing at any time and that this revocation will not cover disclosures made previously in reliance on this consent
- I understand that Chesapeake Medical Solutions and its employees, officers and medical staff are released from legal responsibility or liability for the release of the information in accordance with this consent.

Signature of patient, or representative, if minor Date

Name and relationship of representative Witness Date

Date picked up Picked up by