15825 Shady Grove Road, Suite 140, Rockville, MD 20850 | 5530 Wisconsin Avenue, Suite 530, Chevy Chase, MD 20815 | 2639 Connecticut Avenue, Suite C100, Washington DC 20008
20410 Observation Drive, Suite 210, Germantown, MD 20876 | 18550 Office Park Drive, Montgomery Village, MD 20886
1115 U Street NW, Suite 201, Washington, DC 20009 | 5413 Cedar Lane, Suite 203C, Bethesda, MD 20814 | 43810 Central Station Drive, Suite 160, Ashburn, VA 20147
Telephone: 301.869.9776 | Fax: 301.216.2592

I, _____ authorize the release of my private health

Patient's Full Name

information to _____ _____

Name *Relationship*

I understand this information may include test results, referral information, scheduling, cancelation, or confirming appointments, as well as any other medical information pertinent to my care.

I acknowledge that this authorization is valid throughout my relationship with **Comprehensive Primary Care & Associates, L.L.C..** I understand that I may revoke this agreement at any time by submitting a request in writing.

OR

I, _____ do not want my private health

Patient's Full Name

Information released to anyone at this time. Should I choose to designate someone at a later date, I will submit that request in writing.

SIGN BELOW

_____ _____

Patient's Signature *Today's Date*