



301-330-0006
301-330-0444

info@alldaymedicalcare.com
AllDayMedicalCare.com

702 Russell Avenue, Suite 100
Gaithersburg MD 20877
3915 Ferrara Drive
Silver Spring, MD 20906
3508 Worthington Blvd, Suite 101
Urbana, MD 21704
5525 Twin Knolls Road, Suite 323
Columbia. MD 21045

DISCLOSURE OF PERSONAL HEALTH INFORMATION (HIPPA)

This consent form allows All Day Medical Care Clinic to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information may be used or disclosed to carry out treatment, payment, or health care operations.

Information Release for: _____
(Patients First and Last Name)

Patient's Date of Birth: _____

I hereby authorize All Day Medical Care Clinic to communicate with the individual(s) listed below only for purposes of 1) collecting payment due on my account(s) at All Day Medical Care Clinic and 2) answering questions specific to billing and payment collections on said account(s) 3) release of my protected health information.

Authorized communication can include the following information: date/time (if applicable) of any provided services (or no-shows/late cancellations); type/level of services; name of All Day Medical Care Clinic provider(s); and fees due or paid for any rendered services, missed appointments, cancelled appointments with less than 24 (business) hours' notice, and disclosure of any personal health information.

I understand that once information is disclosed in accordance with this authorization, it may be redisclosed by the recipient(s) and no longer protected by HIPAA Privacy Rules. I further understand that All Day Medical Care Clinic does not have any ability to prevent subsequent disclosures of my information by the recipient(s).

I authorize communication, restricted to the purposes and information as stated above, with the following:

Name: _____ Relationship to Patient: _____

Phone Number: _____ Alt. Phone Number: _____

Mailing Address (Address, City, State, and Zip): _____

Name: _____ Relationship to Patient: Parent/Guardian

Phone Number: _____ Alt. Phone Number: _____

Mailing Address (Address, City, State, and Zip): _____



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Release Information to Primary Care Physician: _____ Yes _____ No (Please Check one)
(If yes was checked off, please fill out portion below)

Name of Primary Care Physician: _____ Phone Number: _____

Address (Address, City, State, and Zip): _____

Release Information to Behavioral Health Provider: _____ Yes _____ No (Please Check one)
(If yes was checked off, please fill out portion below)

Name of Behavioral Health Provider: _____ Phone Number: _____

Address (Address, City, State, and Zip): _____

Release Information to School: _____ Yes _____ No (Please Check one)
(If yes was checked off, please fill out portion below)

Name of School: _____ Contact Name: _____

Phone Number: _____

Address (Address, City, State, and Zip): _____

THIS AUTHORIZATION TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME EXCEPT TO THE EXTENT THAT ALL DAY MEDICAL CARE CLINIC HAS ALREADY
DISCLOSED INFORMATION BY HAVING ACTED ON MY PRIOR CONSENT.

I understand I may cancel this authorization at any time by providing to the Office of All Day Medical Care Clinic written communication that includes the date this
authorization will end.

Printed Name of Patient: _____ Date: _____

Signature of Patient: _____

If Minor (Patient/Guardian) Signature: _____