J. Richard Lilly, M.D., A.B.F.P. and Associates
5804 Baltimore Ave.
Hyattsville, MD. 20781
(301) 927-7800
(301) 209-9474 (Fax)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO J. RICHARD LILLY, M.D. AND ASSOCIATES

RELEASE INFORMATION FROM:
(DOCTOR OR HOSPITAL ADDRESS)

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

RELEASE INFORMATION FOR:

Patient Name :_____ DOB:_____

Address:_____ Social Security Number: _____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

_____ ALL MEDICAL RECORDS _____ LAST 2 YEARS ONLY _____ OTHER (Explain)_____

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE:

_____ Referral to specialist _____ Insurance _____ Workers Comp
_____Legal Investigation _____ Disability Determination _____ Personal
_____ Other (Specify)_____

At the request of the individual, I _____, do hereby authorize you to release my medical
(Patient's name)
information to J. Richard Lilly M.D. and Associates:

SEND INFORMATION TO:

J. Richard Lilly, M.D., A.B.F.P.
and Associates
5804 Baltimore Avenue
Hyattsville, MD 20781
(301) 927-7800
Fax: (301) 209-9474

_____ _____
Signature of individual or guardian Date