The Senator William and Ellen Proxmire Memory Clinic
At Copper Ridge

Authorization for Release of Medical Information

IMPORTANT: This form must be completed, signed and given to the patient's clinician so that the patient's medical records will be sent to the clinic.
Please do not return the form to the clinic.

Name of Patient: _____ D.O.B.: ___/___/_____
Type or Print Name

I authorize and request: _____
Name of Physician and/or Facility

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) ____ - _____ Fax Number: (____) ____ - _____

Records requested: History & physical (within the past year), hospital discharge summaries (within the past 3 years), all previous neurologic, psychiatric, and/or dementia evaluations, all brain imaging studies and laboratory values done within the past 2 years.

Send to: *The Senator William and Ellen Proxmire Memory Clinic*
At Copper Ridge
710 Obrecht Road
Sykesville, MD 21784
Phone: (410) 552.3211
Fax: (410) 795.2807

Patient Signature: _____ Witness Signature: _____

Print Patient's Name: _____ Date: ____/____/_____

Patient's Address: _____

In the event the patient is unable or unavailable to sign:

Signed: _____

Printed Name: _____

Address: _____

Relationship to Patient: _____