# Consent Form – Evidence-Based Programs

## AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF MEDICAL INFORMATION AND MEDICAL RECORDS

I, _____, permit Peninsula Regional Medical
(Print Name)
Center, its providers, Peninsula Home Care, the MAC, Inc. Living Well Center of Excellence to share information about me, such as my medical condition, blood pressure readings and any other necessary information with people who help with my care, including physicians, nurses, therapists, health care agencies, state or federal agencies.

I also specifically authorize any health care provider or health care facility that has provided care to me to share any information requested by Wicomico County Health Department. Those providers who may release the requested information includes: physicians, nurses, therapists, health care agencies, hospitals and state or federal agencies.

I understand that my participation is voluntary and that signing this consent form is optional and not required for participation in a community workshop. In addition, I understand that I may revoke this authorization at any time by notifying MAC, Inc. Living Well Center of Excellence in writing.

A copy of this authorization with my signature may be used with the same effect as an original.

This authorization will expire one (1) year from date unless otherwise specified.

_____ _____

Date Signature of Patient or Authorized Representative

Telephone Number _____ Last 4 digits of Social Security # _____