

MEDICAL RECORDS RELEASE REQUEST

PATIENT NAME: _____ DOB: _____
(PRINT)

ADDRESS: _____ HOME PHONE: _____

CELL PHONE: _____

AUTHORIZATION:

I, _____, authorize release of my medical records as follows:

RELEASE MY RECORDS FROM: _____
(Physician, Person or Company)

(Address)

(Phone) (Fax)

TO: _____
(Physician, Person or Company)

(Address)

(Phone) (Fax)

Include: all records and reports from the past 5 years. OR I request _____ (#of years) of records
Include Only: Lab Reports Radiology Reports ECG Results Physician Notes

Special Instructions: _____

I DO I DO NOT authorize release of information related to Aids, HIV, Psychiatric care and/or treatment, alcohol/drug use.

The purpose of this disclosure is:

Referral to Specialist Physician Change Workers' Comp Disability
 Other: _____

I hereby authorize disclosure of the health information for the above named patient. The authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that Maryland State laws permit a fee of \$22.18 for processing as well as \$0.73 per page for copying medical records. If you are requesting records prior to 1999 there is an additional off site storage retrieval fee of \$50.00.

Signature of Patient or Power of Attorney

Date