  **Rockville Internal Medicine Group**

 **1201 Seven Locks Road, Ste. 111**

 **Rockville, MD 20854**

 **Ph: 301-762-5020 Fax: 301-294-7569**

 **www.rimgmd.com**Seven Locks Road.RRRR

1201 Seven Locks Road, Suite 111, Rockville, MD 20854

Phone: 301-762-5020 Fax:301-294-7569

**MEDICAL RECORDS RELEASE REQUEST**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION:**

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

RELEASE MY RECORDS **FROM:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (physician, person or company)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (address)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (phone) (fax)

 **TO:** \_\_\_\_Rockville Internal Medicine Group\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (physician, person, or company)

 \_1201 Seven Locks Road Suite 111 Rockville, MD 20854\_\_\_\_\_\_

 (address)

 301-762-5020\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_301-294-7569

 (phone) (fax)

Include: \_\_\_\_\_\_\_\_ all records and reports from the past 5 years

 OR

 I request \_\_\_\_\_\_\_\_\_\_ years records (# of years)

Include Only: \_\_\_\_ Lab Reports \_\_\_\_ Radiology Reports \_\_\_\_ EKG Results \_\_\_\_ Physician Notes

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 $22.88 for processing as well as $0.76 per page for copying medical records.

If you are requesting records prior to 1999 their is an additional off site storage retrieval fee of $50.00.

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Signature Date