AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

______________________________ (PRINT patient's full name)

______________________________ Birth date (Mo/Day/Yr)

______________________________ (Street address)

______________________________ Social security number

______________________________ (City, state, zip code)

______________________________ Phone (Home)

At the request of the individual, I ______________________, (Patient's Name or Parent Name if patient is under 18)

do hereby authorize ______________________________(Name of Facility) to release:

RECORDS ARE REQUESTED FOR THE FOLLOWING DATES/TIME PERIOD:______________________________

_____DISCHARGE SUMMARY	_____PATHOLOGY REPORTS	_____EMERGENCY REPORTS
_____HISTORY & PHYSICAL	_____LABORATORY REPORTS	_____ALL RECORDS
_____PROGRESS NOTES	_____RADIOLOGY REPORTS	_____LAST 2 YEARS ONLY
_____OPERATIVE NOTES	_____ECG/EEG/CARDIC CATH	_____OTHER (Be specific)__________

_____ 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.

INFORMATION RELEASE TO: ______________________________
Name of Company/Agency/Facility/Person

____
Street address

____
City, state, zip

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST	_____INSURANCE	_____WORKERS COMP	_____LEAVING PRACTICE
_____LEGAL INVESTIGATION	_____DISABILITY DETERMINATION	_____PERSONAL	_____RELOCATING

OTHER (SPECIFY)______________________________

Please provide current DAYTIME telephone number in the event we need to contact you: (_____)______________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect 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.

______________________________ ______________________
Signature of individual or guardian or **Date**
Personal Representative of patient's estate (Power of Attorney must be on file with office or accompanying this request.)

NOTE: There will be a charge for a personal copy or the permanent transfer of your records. Maryland State Rates apply as pages 1-35 = $0.73 each page, pages 36 and above = $.20 each page, plus first class postage and a preparation fee of no more than $22.18. RECORDS WILL BE MAILED OR FAXED ONCE PAYMENT HAS BEEN RECEIVED.

Please allow at least 7-10 business days for records to be processed once payment is received.

Office Use Only : Prep fee	= __________	
# pgs 1-35 _______ X $0.73	= __________	**Date completed** __________
# pgs 36 & up_______ X $0.20	= __________	**Initials** __________
Postage	= __________	**Payment collected: Cash/Ch/CC**
TOTAL	= __________	**Total collected:** __________