

**Women's Health Specialists of Montgomery County PA**

Gynecology-Gynecologic Oncology  
6301 Executive Boulevard  
Rockville, MD 20852  
Phone: (301) 770-4967

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

PRINT Patient's Full Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

At the request of the individual, I \_\_\_\_\_, (Patient's name or parent's name if patient is under 18), do hereby authorize \_\_\_\_\_ (Name of facility) to release:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Pathology Reports    | <input type="checkbox"/> Emergency Reports         |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Reports   | <input type="checkbox"/> All Records               |
| <input type="checkbox"/> Progressive Notes  | <input type="checkbox"/> Radiology Reports    | <input type="checkbox"/> Last 2 Years Only         |
| <input type="checkbox"/> Operative Notes    | <input type="checkbox"/> ECG/EEG/Cardiac Cath | <input type="checkbox"/> 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 RELEASED TO:**

Name of Company/Agency/Facility/Person \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PURPOSE OF DISCLOSURE**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Insurance                | <input type="checkbox"/> Worker's Comp | <input type="checkbox"/> Leaving Practice |
| <input type="checkbox"/> Legal Investigation    | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Personal      | <input type="checkbox"/> Relocating       |
| <input type="checkbox"/> 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 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.

Date \_\_\_\_\_

**Signature of Individual or Guardian or 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 thru 35 @ 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.**

<b>OFFICE USE ONLY</b>	
Prep Fee _____	Date Completed _____
Pages 1-35 ____ x73¢ = _____	Initials _____
Pages 36+ ____ x20¢ = _____	Payment Cash / Check / Credit Card
Postage _____	Total Collected: _____
<b>TOTAL</b> _____	