MEDICAL RECORDS RELEASE/DISCLOSURE OF INFORMATION

Email Address: _____

I, _____, hereby authorize and request
(PLEASE PRINT CLEARLY)

(physician/facility name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Date of Birth: _____

to release a copy of my medical records to the following:

Facility/Practice Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

This should include records for the following:

- ○ Any and all information related to past and present medical histories, diagnostic and laboratory testing results as related to diagnoses and treatment.
- ○ Medical records concerning the following date(s) of service(s): _____
  _____
- ○ Diagnostic and laboratory testing results for time period: _____
- ○ Other specified records: _____
  _____

I understand that the medical records to be released may contain information related to my HIV status, AIDS, Sexually Transmitted Infections, Alcohol and/or Drug use, or Mental Health services, and I hereby authorize release of this information as well. This authorization is valid for a period of one (1) year from the date below and may be withdrawn at any time.

I understand and acknowledge that I may be assessed a fee for the release of my medical records. I am aware that the State of Maryland regulates this fee and the current charge for preparation and handling is $22.88 and the rate for copying my health information is $.76/page as well as any applicable postage.

_____ _____
Signature Date

Please share with us your reason for release/transfer of your medical records:

_____

_____

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