# MEDICAL RECORDS RELEASE FROM

**Date:** _____

**I,** _____ **D.O.B.:** ____ / ____ / _____
**(Last) (First) (M.I.)** **(M/D/Year)**

**HEREBY AUTHORIZE, Maryland Endocrine P.A.,to release my medical records and any information including the diagnosis, notes, test results, and records of any treatment or examination rendered to me during the period:**

**From** _____ **to** _____

**To:** _____
**(Dr's Name or practice name)**

**Street:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **Fax:** _____

I understand that this authorization shall be effective for a period of one year unless otherwise noted. 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 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 is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

NOTE: All requests for ***printed*** chart copies may be charged at the rates established acceptable by Maryland State Law.

X _____ X _____
Signature Witness

_____ _____
Name – **PRINTED** Patient's Social Security #

_____
Street

_____
City, State, and Zip Code

**INSTRUCTIONS**

Maryland Endocrine is required by law to have you complete and sign this written request before any records may be released. You may return the completed and signed request to our office in person, or by FAX, email, or USPS mail.