RECORDS RELEASE TO

Date: _____

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

HEREBY AUTHORIZE,

Provider: _____
(Dr's Name or practice name)

Street: _____

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

Phone: _____ **Fax:** _____

TO RELEASE TO: Maryland Endocrine P.A., FAX # 301-953-3543

Any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ **to** _____

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.

All requests for 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

Provide this signed form to the provider who currently has the records. That provider may require a Records Release form that requires your signature. **Do not return this form to our office.**