Medical Records Release

Instructions:

Records release required by federal law to be completed and signed by written authorization. Complete this form in its entirety. This release may be returned in person, by mail, by fax, or email.

Date: _____

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

HEREBY AUTHORIZE, Maryland Endocrine P.A., to:

- ☐ Release my medical records to the party listed below
- ☐ Receive my medical records from the party listed below

This is to include diagnoses, notes, test results, and records of any treatment for examination rendered to me during the period of the dates from: _____ to: _____

Party: _____
(Dr's Name or practice / facility name)

Street Address: _____

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 a written notification, but it will not affect any information released prior to the cancellation. I understand that the information used may be subject to redisclosure 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 I sign the authorization.

Records Release Restrictions: _____

_____

X_____ X_____
Patient / Responsible Party Signature Witness

_____ _____
Signee's Name – PRINTED Signature Date

_____
Patient Street Address

_____
City, State, and Zip code