MEDICAL RECORDS RELEASE AUTHORIZATION FORM

PATIENT NAME _____

ADDRESS _____

TELEPHONE # _____

SSN _____ **DOB** _____

I authorize the custodian of the records of _____
(Practice name and address)
_____

to release the following information *(Please check all that apply)*

- ☐ All Records
- ☐ Consultation Notes
- ☐ Operative Reports
- ☐ Laboratory/Pathology
- ☐ Progress Notes
- ☐ Admission Notes

These records are for services provided on the following dates: _____

Please send the records listed above to:

Name _____

Address _____

Phone _____ Fax _____

This authorization shall expire no later than _____ and may not be valid for greater than one year from the date of signature for Maryland medical records.

_____
Signature of Patient or Representative Date

_____
Printed Name of Patient or Representative If Representative, Relationship to Patient