

Request for Medical Release

I authorize the release of my medical information to:

Name of Entity: Carroll Health Group

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fax #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Records to be released from:

Doctor: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fax #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Reason for medical records release: \_\_\_\_\_

- I understand that this request will include health information relative to testing, diagnosis, and/or treatment of HIV, sexually transmitted disease, drug and/or alcohol use. Based on the HIPAA act of 1996 we will not release any medical records relative to psychiatry or mental health issues.
- There will be a charge for the preparation and copying of the medical records for personal use. Fees are assessed in accordance with Maryland State Law. One courtesy copy will be sent directly to the new physician of record.

The releasing office does not guarantee the continued confidentiality of medical information once the requested medical information has been released to the above entity.

Patient Name: \_\_\_\_\_

Patient SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian (Under Seal)

\_\_\_\_\_  
Signature Date