11921 Rockville Pike, Suite 400, Rockville, MD 20852

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

RELEASE TO: ____

PHONE: ______________________ **FAX:**__________________________

RELEASE FROM:____

PHONE:_______________________ **FAX:**__________________________

PATIENT NAME: ____

DOB:________________________ **PHONE:** ___________________________

ADDRESS: ____

CITY: ________________ **STATE:**_________ **ZIP CODE:** ________________

I, ___________________________ **AUTHORIZE AND REQUEST YOU TO PROVIDE A COPY OF:**

____ ALL INFORMATION RELATED TO MY PAST AND PRESENT MEDICAL HISTORY DIAGNOSIS AND TREATMENTS.

____ MEDICAL RECORDS FROM SERVICE DATES: ______________ TO _________________

____ SPECIFIC RECORDS OR TESTS ____

***PLEASE STATE THE REASONS FOR THE REQUEST OR TRANSFER:**

I understand the medical records to be released may contain information related to HIV status, AIDS, sexually transmitted disease, alcohol, drug abuse and mental health services, I also understand that under Maryland law there may be a charge for preparing and copying all or any medical records. This authorization for discloser is valid for a period of one year or until (date) ___________________, whichever is sooner, and may be withdrawn by me at any time except during action taken in response herein.

PLEASE ALLOW 2 TO 3 WEEKS TURN AROUND TIME.

THE REQUEST MUST BE IN WRITING. THERE WILL BE A FEE FOR ALL RECORDS.

SIGNATURE: ____ **DATE:** ___________

WITNESS SIGNATURE: ______________________________________ **DATE:** ___________

www.whspecialists.com ~ phone (301) 770-4967 ~ fax (301) 414-2306 ~ kelly.figueroa@advantiahealth.com