South River Family Medicine
3169 Braverton Street, Suite 201
Edgewater, MD 21037
Phone: 410-956-4911 Fax: 410-956-4939

Patient Information: Print name: _____ Date of Birth: _____

SS# (Last 4 digits) _____Maiden or prior last name: _____Phone #_____

Please release my healthcare information from:

Name of Facility/Provider:

_____

Address: _____

City/State/Zip _____

Phone/Fax Number: _____

Please send my healthcare information to:

Name of designated recipient:

_____

Address: _____

City/State/Zip _____

Phone/Fax Number: _____

Information to be released

Format: Paper ☐ Electronic (CD) ☐

- ☐ Abstract of Health Information
- ☐ Records from_____ to _____ only
- ☐ The most recent 2 years of pertinent information (chart notes, labs, ultrasounds and special tests)
- ☐ Complete Medical Record
- ☐ Other (Specify): _____
- ☐ Billing Records from _____ to _____

Purpose of Request:

- ☐ Continuing Care
- ☐ Workman's Comp.
- ☐ Personal use
- ☐ Disability Determination
- ☐ Other (Specify): _____

Fees for Copying Medical Records

The following fees will apply:
The actual retrieval fee for medical records stored off-site**$**_____.
A base preparation fee of **$**_____ (**waived for patient requests**).
A charge of **$**_____ cents per photocopied page, and the actual cost of postage **$**_____.
These fees must be paid before your records can be released.

My Rights

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing, and present to the office where my information is being released. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or receive copies of the information to be used or disclosed, as provided in the Code of Federal Regulations (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Patient Authorization

I understand that I may be charged the fees shown above for the copying of my medical records. I authorize *Name of Practice* to release my medical records (including medical information related to the diagnosis or treatment for HIV testing, drug and alcohol, or a psychiatric condition) as specified above.

Signature: _____ Date: _____
(Patient, Guardian*****, Authorized Representative*****)
***** Must provide documentation to prove authority to sign on behalf of the patient)

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED