Annapolis Family Medicine

Medical Records Release

NAME: _____ DATE OF BIRTH: _____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

SECONDARY PHONE NUMBER: _____

I hereby authorize Annapolis Family Medicine, LLC to obtain my Protected Health Information from:

NAME: _____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

FAX NUMBER: _____

1. I understand that this authorization will expire 365 days from the date I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that this authorization may be used to obtain any medical information pertaining to substance abuse, mental health, or HIV related testing.

Initials: _____

Records Requested:

☐ Last Office Visit ☐ EKG's
☐ Last Labs ☐ Radiology
☐ Immunizations
☐ Other: _____

Purpose of Disclosure:

☐ Changing Physicians
☐ Personal Use
☐ Continuing Care
☐ Other: _____

_____ _____
Patient Signature Date

_____
Printed Name

☐ Self ☐Parent ☐ Legal Guardian ☐ Other: _____

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