AUTHORIZATION TO RELEASE MEDICAL RECORDS
Calvert Internal Medicine Group

985 Prince Frederick Blvd., S 201, Prince Frederick, MD 20678
Ph - 410-535-2005 – fax 410-535-4850

Your medical records cannot be released until this form is completed and signed by the patient, parent, or legal guardian. As you complete each step, check off the box at the left. Please note there is a fee for copying patient records and for the cost of postage if the records are mailed. Please note copies can be obtain through the patient portal at no cost to the patient.

Step 1 ☐	STEP 1: **Patient Information (Please Print)** Patient Name: ______________________________ Last Name First Name DOB: ______________________________ Phone: ______________________________ Address: ______________________________ ______________________________ ______________________________	Step 2 ☐	STEP 2: **Disclosing Provider** I hereby authorize: ______________________________, M.D. Address: ______________________________ ______________________________ ______________________________ ______________________________ Phone: ______________________________
Step 3 ☐	STEP 3: **Information to be disclosed or released** To release the following information: Please specify: _____ All Records or: ______________________ _____ All Records Except:______________________ _____Only records relating to: ______________________ _____ Records of Treatment from: ________ to ________ Purpose of Disclosure: _____ Coordination of Care _____ Transfer of Care: Why: ______________________ ______________________________	Step 4 ☐	Step 4:**Receiving provider and purpose of disclosure** To: ______________________________M.D. Address: ______________________________ ______________________________ Phone: ______________________________ For: ______________________________ ______________________________

Step 5 ☐

Step 5: **Statement of understanding and signature**

Your signature below indicates that you agree to the disclosure or release of medical information described above and that you understand the following:

- You may revoke this authorization at any time by sending a written request for revocation to the provider named in step 2 above. This revocation, however, will not affect any actions taken by the releasing provider before he/she received your written revocation.
- If you fail to specify an expiration date, this authorization will expire in six (6) months.
- Your medical treatment cannot and will not be dependent upon your signing this authorization.
- You have the right to receive a copy of this authorization.
- You have the right not to sign this authorization.

____
Patient's Signature Date

____
Parent's or Guardian's Signature Date

____
Witness Signature

Step 6 ☐

Step 6: **Sensitive Information**

I AGREE TO THE RELEASE of the information in my medical record that related to drug and/or alcohol abuse, history of psychiatric care, history of sexually transmitted disease, social service consultations, hepatitis testing/treatment, and/or other sensitive information.

____
Signature of Patient or Legal Guardian Date

Step 7 ☐

Step 7: **HIV Information**

IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW.

I AGREE TO THE RELEASE OF THE HIV INFORMATION IN MY MEDICAL RECORD.

____
Signature of Patient or Legal Guardian Date