

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Calvert Internal Medicine Group

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Phone: 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 obtained through the patient portal at no cost to the patient.

STEP 1 <input type="checkbox"/>	<p align="center">Patient Information (Please Print)</p> <p>Patient Name: _____</p> <p>Last Name _____ First Name _____</p> <p>Date of Birth (MM/DD/YYYY) _____ / _____ / _____</p> <p>Phone: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p>	STEP 2 <input type="checkbox"/>	<p align="center">Disclosing Provider</p> <p>I hereby authorize: _____, M.D.</p> <p>Address: _____</p> <p>_____</p> <p>_____</p> <p>Phone: _____</p>
STEP 3 <input type="checkbox"/>	<p align="center">Information to be disclosed or released</p> <p>To release the following information Please specify by checking a box below:</p> <p><input type="checkbox"/> All Records or: _____</p> <p><input type="checkbox"/> All Records except: _____</p> <p><input type="checkbox"/> Only Records relating to: _____</p> <p><input type="checkbox"/> Records of Treatment from: _____ to: _____</p> <p>Purpose of Disclosure:</p> <p><input type="checkbox"/> Coordination of Care</p> <p><input type="checkbox"/> Transfer of Care: Why - _____</p> <p>_____</p>	STEP 4 <input type="checkbox"/>	<p align="center">Receiving Provider and purpose of disclosure</p> <p>To: _____, M.D.</p> <p>Address: _____</p> <p>_____</p> <p>_____</p> <p>Phone: _____</p> <p>For: _____</p> <p>_____</p>
STEP 5 <input type="checkbox"/>	<p align="center">Statement of understanding and signature</p> <p>Your signature below indicates that you agree to the disclosure or release of medical information described above that you understand the following:</p> <ul style="list-style-type: none"> - 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/they 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. <p align="right"> _____ Patient's Signature Date </p> <p align="right"> _____ Parent's or Guardian's Signature Date </p> <p align="right"> _____ Witness Signature </p>		
STEP 6 <input type="checkbox"/>	<p align="center">Sensitive Information</p> <p>I AGREE TO THE RELEASE of the information in my medical records 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</p> <p align="right"> _____ Signature of Patient or Legal Guardian Date </p>		
STEP 7 <input type="checkbox"/>	<p align="center">HIV Information</p> <p>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.</p> <p>I AGREE TO THE RELEASE OF THE HIV INFORMATION IN MY MEDICAL RECORD.</p> <p align="right"> _____ Signature of Patient or Legal Guardian Date </p>		
STEP 8 <input type="checkbox"/>	<p align="center">Release Method / Format Requested:</p> <p>How do you want this information?</p> <p> <input type="checkbox"/> Mail <input type="checkbox"/> Fax (for healthcare providers / organizations as permitted) <input type="checkbox"/> Patient Portal <input type="checkbox"/> DVD / CD (Password Protected) <input type="checkbox"/> Email (Encrypted) <input type="checkbox"/> Other: _____ </p>		

Calvert Internal Medicine Group

Doctors: Barth, Belfonte, Berg, Bright, Browne, Coons, Foster, Gallatin, Rhodes-Height, Judge, Kline, Lowenthal, Mendonca, Moody, O'Keefe, Pirouz, Pomilla, Wisnewski

Nurse Practitioners: Bissett, Drumm, Gaines, Glowacki, Grandjean, Heilig, Knowles, Wallander

Physician Assistants: Brendel, Gaughan, Jones, Keiter, Stofft

updated: 9/30/2022