**Charter Internal Medicine LLC**
**10700 Charter Dr. #200**
**Columbia, MD 21044**
**Phone 410-910-2300 Fax 410-740-9134**

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
**(Print patients full name)** Birth date (Mo/Day/Yr)

_____ _____
(Street address) social security number

_____ _____
(City, state, zip code) Phone (Home)

At the request of the individual, I _____, do hereby authorize **Charter Internal Medicine** to release:

**(patients name)**

_____DISCHARGE SUMMARY
_____HISTORY & PHYSICAL
_____PROGRESS NOTES
_____OPERATIVE NOTES
_____PATHOLOGY REPORTS
_____LABORATORY REPORTS
_____RADIOLOGY REPORTS
_____ECG/EEG/CARDIC CATH
_____EMERGENCY REPORTS
_____OTHER_____
_____

_____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

**INFORMATION RELEASE TO:** _____
NAME (Physician, hospital, agency, ect)

_____
Street address

_____
City, state, zip

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST
_____LEGAL INVESTIGATION
_____INSURANCE
_____DISABILITY DETERMINATION
_____WORKERS COMP
_____PERSONAL

OTHER (SPECIFY)_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
**Signature of individual or guardian or Personal Representative of patient's estate** **Date**

Reason for transferring: _____

Please provide current telephone number in the event we need to contact you: _____

# Charter Internal Medicine

## FEE FOR COPYING PATIENT RECORDS

The charge for this service is based on Maryland law.

* A preparation fee of $22.88 (**This fee may not be charged to patients**), plus
* A copying charge of $.76 per page or $5.00 for a disk; plus
* The actual cost of postage.

This law is codified in Maryland law at Health-General Article § 4-304(c)(3).

**You will be pre-billed for the records. As soon as the Invoice is paid your records will be mailed.**

**Fee for Copying Medical Records**
*(Records going to another Physicians office due to a transfer or to you directly.)*

**All fees are based on HIPAA guide lines.**

**Please allow 10-14 business days**
for records to be received by the requestor.

*FAX COMPLETED FORM TO 410-740-9134*