CHARTER
INTERNAL MEDICINE

2470 Longstone Lane, Suite I
Marriottsville, MD 21104
Phone: 410-910-2300
Fax: 410-740-9134

Authorization for Release of Medical Records

Patient Name: last, first _____ Date of Birth (mm/dd/yyyy) _____

Street Address _____ Preferred Contact Phone _____

City, State, Zip Code _____ Email Address _____

I, _____, do hereby authorize Charter Internal Medicine to release my medical records.
(Patient's Name)

I request that my records be released to me in the following format:

- ❑ Paper Copy (Fee of $0.76 per page plus postage)
- ❑ PDF on CD (Flat rate of $6.50 including postage)
- ❑ PDF via email/secure file sharing (No Charge)

Please release the indicated records for dates _____ to _____:

- ❑ History & Physical/Evaluation Report
- ❑ Office Progress Notes
- ❑ Emergency/Urgent Care Records
- ❑ Hospital Inpatient Records
- ❑ Pathology Reports
- ❑ Laboratory Results
- ❑ Radiology Reports
- ❑ Immunization Records
- ❑ All Available Records
- ❑ Other: _____

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

Purpose of Disclosure:
- ❑ Continuation of Care
- ❑ Change of Physician
- ❑ Legal Investigation
- ❑ Disability Determination
- ❑ Insurance/Billing
- ❑ Worker's Comp/Auto Accident

I hereby authorize disclosure of the indicated health information for the above named patient. This authorization shall be in force and effect for 12 (twelve) months from the date of signature. I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent that information has already been released in reliance upon this authorization. I understand that this authorization is voluntary and my treatment will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
(Signature of Patient/Guardian/Personal Representative) (Date)