AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ (Print patients full name)

_____ (Birthdate (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:
(Patient's Name)

DATES OF_____

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

_____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 of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST	_____INSURANCE	_____WORKERS COMP	_____CHANGE DOCTOR
_____LEGAL INVESTIGATION	_____CONTINUING CARE		_____PERSONAL
_____DISABILITY DETERMINATION	OTHER (SPECIFY) _____		

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

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**

NOTE: There will be a charge for a personal copy or the permanent transfer of your records. You will be invoiced before records are mailed. See accompanying information page for fees.

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; plus
* The actual cost of shipping and handling

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 your home address)

CIM does not charge if records are needed for a continuing care purpose.
An example of this: Records needed for a referred specialist OR to a sister facility.

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 410-910-2310