CHARTER
INTERNAL MEDICINE

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

Request for Release of Medical Records

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

(Street Address) _____ Preferred Contact Phone _____

(City, State, Zip Code) _____

I, _____ (Patient's Name), do hereby authorize _____ (Doctor/Practice/Hospital/Facility)
to release the following information to Charter Internal Medicine, LLC:

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: _____

Purpose of Disclosure: ❑ Continuation of Care ❑ Change of Physician

- ❑ 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.

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)

*****Patient is responsible for any fees associated with the copying and transmitting of medical records*****