AUTHORIZATION TO RELEASE MEDICAL RECORDS

Calvert Internal Medicine Group
985 N. Prince Frederick Blvd., Suite 201, Prince Frederick, MD 20678
Phone: 410-535-2005 Fax: 410-535-4850

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 to 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 ☐ **Patient Information (Please Print)**

Patient Name: _____
Last Name First Name

Date of Birth (MM/DD/YYYY) ____/____/____

Phone: _____
Address: _____
_____
_____

STEP 2 ☐ **Disclosing Provider**

I hereby authorize:
_____, M.D.

Address:
_____
_____
_____

Phone: _____

STEP 3 ☐ **Information to be disclosed or released**

To release the following information
Please specify by checking a box below:

- ☐ All Records or: _____
- ☐ All Records except: _____
- ☐ Only Records relating to: _____
- ☐ Records of Treatment from: _____ to: _____

Purpose of Disclosure:

- ☐ Coordination of Care
- ☐ Transfer of Care: Why - _____

_____

STEP 4 ☐ **Receiving Provider and purpose of disclosure**

To: _____, M.D.

Address: _____
_____
_____

Phone: _____
For: _____
_____

STEP 5 ☐ **Statement of understanding and signature**

Your signature below indicates that you agree to the disclosure or release of medical information described above that you understand the following:

- 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.

_____
Patient's Signature Date

_____
Parent's or Guardian's Signature Date

_____
Witness Signature

STEP 6 ☐ **Sensitive Information**

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

_____
Signature of Patient or Legal Guardian Date

STEP 7 ☐ **HIV Information**

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.

I AGREE TO THE RELEASE OF THE HIV INFORMATION IN MY MEDICAL RECORD.

_____
Signature of Patient or Legal Guardian Date

STEP 8 ☐ **Release Method / Format Requested:**

How do you want this information?

- ☐ Mail
- ☐ Fax (for healthcare providers /organizations as permitted)
- ☐ Patient Portal
- ☐ DVD / CD (Password Protected)
- ☐ Email (Encrypted)
- ☐ Other: _____

Calvert Internal Medicine Group

Providers: **(Drs)**: Barth, Belfonte, Berg, Bright, Browne, Coons, Foster, Gallatin, Judge, Kline, Lowenthal, Mukesh Mathur, Manoj Mathur, Mendonca, Moody, O'Keefe, Pirouz, Pomilla, Rhodes-Height, Wisniewski. **(NPs):** Bissett, Cho, Drumm, Gaines, Glowacki, Grandjean, Knowles, Wallander **(PA's):** Brendel, Eggan, Gaughan, Jones, Keiter, Rothhaas, Stofft **(LCPC's):** Edwards, Washington

updated: 12/31/2024