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PATIENT MEDICAL RECORDS REQUEST
 Authorization to Release Medical Information & Processing Form

1. Patient Information

Last Name		First Name	
DOB		SSN	
Street Address		City, State, Zip Code	

2. Information to be disclosed:

All Medical Records Itemized Billing Specific: _____
(chart notes, reports, consults, etc)

3. Dates of Information to be disclosed:

From: _____ to _____
(month/year) (month/year)

4. Dispatch Method:

I will pick up Mail to address above Other: _____
 Fax: _____, Attention: _____

I understand that processing will not begin until all of the above information has been provided. I understand that request processing may take 7-10 business days and all requests are fulfilled in the order they are received. I understand that my records will be released upon receipt of full records fee payment.

 Signature

 Date

To be completed by Medical Records Department

<input type="checkbox"/> \$22.22 Preparation Fee (only applicable to third-party recipients) <input type="checkbox"/> Cost per page: \$0.76 <input type="checkbox"/> Dispatch Fee (postage/handling) Total # of pages: _____ Total Cost: \$ _____

*Under 'Maryland Health-General Article Section 4-304(c)(3)' it is within the physician's right to charge a Medical Records search fee, cost per page, and dispatch fee for all Medical Records Requests from patients or their 'personal representatives'.