128 Lubrano Drive, Suite 301, Annapolis, MD 21401

410-544-4263 *1

Release Medical Records From:
Doctor/Hospital: ____
Street Address: ____
City, State, Zip Code: ____
Phone Number: ____

Release Medical Records To:
Name of Company/Agency/Person: ____________________________
Street Address: ____
City, State, Zip Code: ____
Phone Number: ____

Patient Information:

Patient Full Name: ____________________________________
Street Address: ______________________________________
City, State, Zip Code: __________________________________
Date of Birth: ____
Daytime Phone: ______________________________________
Alternate Phone: ______________________________________

Purpose of Records Release:

____ Referral to Specialist ____ Permanent Transfer _____Personal ____Insurance ____Other

___ I understand that information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), HIV, and other communicable disease, Behavioral health care, and treatment of alcohol and/or drug abuse, my signature releases such information.
____I may refuse to sign this authorization form.
____I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken.
____I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that received the information.
____ I release Annapolis Hand Center LLC and its employees from any legal responsibility or liability of the above information to the extent indicated and authorized herein.

____ ______________________
Patient Name (Printed) Relationship to Patient

____ ______________________
Signature Date