Chesapeake Women's Care, P.A.

2000 Medical Parkway, Suite 306
Annapolis, MD 21401
Phone 410-571-9700 • Fax 410-571-9710

Medical Records Release/Request Form

Please: _____ Send my medical records from Chesapeake Women's Care to:
_____ Release my medical records to Chesapeake Women's Care from:

_____

_____

_____

Patient's Name and Date of Birth: _____

Patient's Address: _____

_____

Please release:

_____ The medical records for the period _____ to _____

_____ Indicate specific records needed: _____

I understand the medical records to be released may contain information related to HIV status, AIDS, sexually-transmitted diseases, alcohol or drug use, or mental health services. I hereby authorize the release of this information.

I understand there is a fee to obtain/send these records and that this is my responsibility. The fee is based on the following guidelines per Maryland Law:

Copying (includes labor and supplies)	$0.76 per page
Mailing	Actual cost to mail
Preparation fee (This fee may not be charged to patients.)	$22.88

I understand that I have the right to revoke this authorization at any time in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company.

This authorization for disclosure is valid for a period of (1) one year and may be withdrawn by me at any time except during an action taken in response thereon.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

❒ Please check box if you're leaving our practice.

❒ Reason for transfer: _____