AAMG Annapolis OB-GYN

CONSENT TO RELEASE MEDICAL RECORDS TO ANNAPOLIS OB-GYN

I hereby authorize the release of my medical records _____
Print Patient's Name

_____
Patient's Full Address

_____ _____
Patient's DOB Patient's Previous Last Name

_____ _____ _____
Patient's Home Phone No. Patient's Work Phone No. Patient's Cell No.

Authorization to release the following records:

- Abstract of Health Information
- The most recent 2 years of pertinent information (chart notes, labs, radiology and special tests)
- Complete Medical Record
- Records from _____ to _____ only
- Other (Specify): _____

from:_____M.D.
Prior Practice/Physician's Full Name

_____
Address of Medical Practice

_____ _____
Provider's phone number Provider's fax number

Practice Sending Records – Please Note Patient's Forwarding Instructions Below:

Please mail records to: (Please check one only)

_____ Patient (at above Address)

_____ AAMG Annapolis OB-GYN
2000 Medical Parkway, Suite 304
Annapolis, Maryland 21401
Phone 443-837-1230
Fax 667-204-7240

NOTE TO PATIENT: If you would like a copy of these records, please have them mailed directly to you so that you can make a copy for your personal file prior to giving them to Annapolis OB/GYN. We are not responsible for giving you a copy of records that are forwarded to us from another provider. You will be charged a fee if you request a copy of these records from AAMG Annapolis OB-GYN.

Date of upcoming visit with AAMG Annapolis OB/GYN: _____

Patient's Signature _____ Date of Request: _____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall not have a termination date.

Thank you for giving us the complete information we are required to ask for under the HIPAA Federal Privacy Act
Updated 7/29/2020