

LUMINIS HEALTH OB/GYN – ANNAPOLIS
CONSENT TO RELEASE MEDICAL RECORDS TO Luminis OB-GYN - Annapolis

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 Preferred Phone #

Authorization to release the following records:

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

For OB Transfer Patients:

- Current Prenatal Records – Progress Notes, Lab results and ultrasound reports for this current pregnancy

From: _____

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: _____ Patient
(ADDRESS ABOVE)

_____ Luminis Health OB-GYN - Annapolis
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 Luminis Health OB/GYN – Annapolis.

Patient's Signature _____ Date of Request: _____

Date of Upcoming Appointment with Luminis Health OB/GYN – Annapolis: _____

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