# Medical Record Release of Information Authorization Form

WHO

**Be sure to complete all fields so that you can be contacted with any issues that may arise. Failure to provide any of these fields will result in delays of the delivery of the medical information.**

**Patient Name:**_______________________________ **Date of Birth:** _____ / _____ / _________ **SSN #: (last 4)-** ______________

**AKA or Maiden Names:** ____________________________________________________________________________

**Patient Address:** ________________________________________________________________________________

**City:** ___________________________________________**State:** _____ **Zip Code:** ____________ **Phone:** (   ) _____ - ________

**Email:** _______________________ @ ___________________________ . _______ **Fax:** (   ) _____ - ________

WHERE

## Doctor you would like information from

Calvert Orthopaedics and Sports Medicine
110 Hospital Road Suite 201
Prince Frederick, MD 20678
**PH:** (410) 535-1343
**Fax:** (410) 535-6954

## Where you would like info sent to

**Please indicate all fields even if you would like the records faxed. Larger files cannot be faxed and RRS will need a complete mailing address**

☐ Self

**Doctor Or Facility Name:**_______________________________

**Address:** __________________________________________

**City:** ____________________________________________

**State:** _____ **Zip Code:** __________ **Fax:** (   ) _____ - _______

WHAT

**In order to receive the fastest services please specify the information that is being requested. Larger files will take longer to process and deliver. Reducing requests to the minimum necessary allows RRS to provide the quickest turnaround times.**

**Dates of Service: - From:** ________ \\ ________ **- To:** ________ \\ ________

**Incident or Injury Date:** ________ \\ ________

**Specific Information:** ________________________________

***Please select the format:***

☐ password-encrypted CD
☐ paper records

WHY

## Purpose of Disclosure - Please select one:

☐ Referral to Specialist
☐ Legal Investigation
☐ Transfer of Care
☐ Insurance
☐ Disability Determination/ Claim
☐ 2nd Opinion
☐ Workman's Comp
☐ Personal
☐ Other: _______________

Legal Requirements

By signing this authorization I agree to the following:

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization.

Unless otherwise revoked, this authorization will expire six months from the date from which it was originally signed.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure continued treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

My evaluation, diagnosis, and/or treatment relating to the conditions listed below may be released to the requestor identified above for the following type of records unless otherwise indicated. AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Signature

**I understand that there may be a fee for this service.**

**Requests cannot be processed without proper authorization. Minors must have a parent signature. Individuals requesting records on deceased or adult patients must provide the required Power of Attorney or other supporting legal documents.**

______________________________________________________________ Date: _______________

Signature of Patient or Authorized Representative