

# Chesapeake Women's Care, P.A.

2003 Medical Parkway, Suite 370

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)	\$0.69 per page
Mailing (if mailed to patient or other provider)	Actual cost to mail
Preparation fee (if records are mailed or handed to patient)	\$0
Preparation fee (if records sent to another provider)	\$21.00

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This authorization for disclosure is valid for a period of (1) one year and may be withdrawn by me at any time except during an action taken in response thereon.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