Prime Medical
2 W Rolling Crossroads # 206
Catonsville, MD 21228
Phone 410-402-9990
Fax 410-402-9991

REQUEST FOR RELEASE OF MEDICAL RECORDS

To:_________________________________Ph:_______________Fax:________________

To:_________________________________Ph:_______________Fax:________________

To:_________________________________Ph:_______________Fax:________________

To:_________________________________Ph:_______________Fax:________________

I,___________________________(patient/client), (birthdate) _______________ hereby request that you release confidential health information by releasing a copy of my medical records, or a summary or narrative of my protected health information to the entity listed above

PLEASE RELEASE THE FOLLOWING RECORDS:

___OPERATIVE REPORTS ___RADIOLOGY REPORTS

___LAB REPORTS ___DISCHARGE/TRANSFER SUMMARY

___PROGRESS NOTES

TREATMENT DATES REQUESTED:____

___ I understand that i have the right to revoke this authorization at any time

___I understand this consent expires one year from the date signed below unless indicated otherwise

___I acknowledge that I have read and fully understand this authorization

Signature of patient/client:________________________________Date:________________