ANNAPOLIS FAMILY MEDICINE

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Medical Records Request Form

Name : _____ DOB : _____

Home Address : _____

City : _____ State : _____ Zip : _____

Phone Number : _____

I hereby authorize Annapolis Family Medicine, LLC to obtain/release my medical records to/from:

Provider or Practice Name : _____

Address : _____

City : _____ **State :** _____ **Zip :** _____

Phone Number : _____ **Fax Number :** _____

1. I understand that this authorization will expire 365 days from the date I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying Annapolis Family Medicine in writing. Revocation will be effective on the date notified, except to the extent action has already been taken in reliance upon this authorization.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that this authorization may be used to obtain any medical information pertaining to substance abuse, mental health, or HIV related testing

Records Requested

- ❑ Last Office Visit
- ❑ Last Lab Results
- ❑ Immunizations
- ❑ EKG/Cardiac Testing
- ❑ Radiology
- ❑ All of the above (3 years)

Purpose of Disclosure

- ❑ Changing Physicians
- ❑ Personal Use
- ❑ Continuing Care

Patient Signature : _____

Printed Name : _____ Date : _____