



Request for Medical Records Release

I authorize the release of my medical information from:

Carroll Health Group
193 Stoner Avenue, Suite 110
Attn: Medical Records
Westminster, MD 21157
Phone: 410-871-7074
Fax: 410-469-5096

Please indicate which office you are requesting records from:

Primary Care Cardiology Endocrinology
 Neurology Orthopaedics General Surgery

Records to be released to:

Doctor: _____
Address: _____

Fax#: _____ Phone #: _____

Reason for medical records release: _____

- I understand that this request will include health information relative to testing, diagnosis, and/or treatment of HIV, sexually transmitted disease, drug and/or alcohol use. Based on the HIPAA act of 1996 we will not release any medical records relative to psychiatry or mental health issues.
- There will be a charge for the preparation and copying of the medical records for personal use. Fees are assessed in accordance with Maryland State Law. One courtesy copy will be sent directly to the new physician of record.

The releasing office does not guarantee the continued confidentiality of medical information once the requested medical information has been released to the above entity.

Patient Name: _____ Patient DOB: _____

Patient Phone Number: _____ Patient SSN (last 4 digits): _____

Appointment Date records needed for: _____

Patient/Guardian Signature

Date