



# Medical Access

19504 AMARANTH DRIVE, GERMANTOWN MD 20874  
PH (301) 428-1070 . FAX (301) 428-3192

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## MEDICAL RECORDS RELEASE/DISCLOSURE OF INFORMATION

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I, \_\_\_\_\_ (Patient Name) \_\_\_\_\_ (Date of Birth)

hereby authorize and request you to release a copy of my medical records to Medical Access at the above address.

This should include records for the following:

- ( ) Any and all information related to past and present medical histories, diagnoses, and treatments
- ( ) Medical records concerning the following date(s) of service: \_\_\_\_\_

I understand that the medical records to be released may contain information related to my HIV status, AIDS, Sexually Transmitted Diseases, alcohol and/or drug use, or mental health services, and I hereby authorize the release of this information as well.

This authorization is valid for a period of one (1) year from the date below and may be withdrawn by me at anytime.

\_\_\_\_\_  
(Patient or Parent/Guardian Signature)

\_\_\_\_\_  
(Date)