MEDICAL ACCESS/GPCA

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MEDICAL RECORDS RELEASE/DISCLOSURE OF INFORMATION

I,_____ Date of Birth: _____

Authorize and request:

Physician/Facility Name: _____ City: _____

State: _____ Zip: _____ Tel: _____

Fax: _____

To release a copy of my medical records:

_____ All information related to my past and present medical history diagnosis and treatments

_____ Medical records from service dates:_____ to _____

_____ Laboratory/pathology/Diagnostic records

_____ Other

Please release the records to:

Physician/Facility Name: _____ City: _____

State: _____ Zip: _____ Tel: _____

Fax:_____

I understand that the medical records to be released may contain information related to my HIV status, AIDS, Sexually Transmitted Infections, Alcohol and/or Drug use, or Mental Health services, and I hereby authorize 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 This authorization is valid for a period of one (1) year from the date below and may be withdrawn at any time.

I understand and acknowledge that I will be charged a fee for the release of my medical records. I am aware that the State of Maryland regulates this fee and the current rate for copying my health information is $.76 per page and the rate for preparation and handling is $22.88 as well as any applicable postage.

The reason for release/transfer of your medical records:

__ Moved to another area __ Insurance Change __ Not satisfied with service

__ Other _____

_____

Signature:_____ Date:_____