THE CAMALIER BUILDING, SUITE 506 · 10215 FERNWOOD ROAD · BETHESDA, MD 20817 · TEL (301) 530-1010 · FAX (301) 897-8597

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I authorize:

OrthoBethesda
10215 Fernwood Rd.
Suite 506
Bethesda, MD 20817

To release records to:

______________________ Name of receiving person or organization

______________________ Phone Number

______________________ Street Address

______________________ Fax Number

______________________ City, State, Zip Code

______________________ E-mail

Records to be released:

- ☐ Entire Record
- ☐ Office Notes
- ☐ Operative Reports
- ☐ Imaging Reports (MRI, CT, Ultrasound, Bone Scan Report)
- ☐ EMG reports
- ☐ Lab Reports
- ☐ Physical Therapy Records
- ☐ X-ray CD ($10.00)
- ☐ X-ray printouts (on paper)
- ☐ Itemized Bill

______________________ Treating Physician

______________________ Body Part

______________________ Dates of Services

Patient Information:

______________________ Name

______________________ Date of Birth

______________________ Street Address

______________________ Phone Number

______________________ City, State, Zip Code

______________________ Patient/Guardian Signature Date

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire one year from the date of my signature, unless I revoke the authorization prior to that time.