CARROLL HEALTH GROUP

A LifeBridge Health Partner

Request for Medical Records Release

I authorize the release of my medical information to:
Name of Entity: Carroll Health Group

Address:

Fax #: _____ Phone #: _____

Records to be released from:
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. Fees are assessed in accordance with Maryland State Law.

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 SSN (last 4 digits): _____
Patient DOB: _____

_____ _____
Patient/Guardian Signature Date