Bethesda Spine & Posture
4733 Elm St. Suite 300, Bethesda, MD 20814
Tel: 301.656.2435 • Fax: 301.986.6960
bethesdaspineandposture@gmail.com

Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth: _____
(also list maiden name/other names used)

I hereby request and authorize:
Bethesda Spine & Posture
4733 Elm Street, St.300
Bethesda, MD 20814
Phone: 301.656.2435 Fax: 301.986.6960

_____To Disclose information to: _____To Receive Information from:

Name/Provider: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

Information to be disclosed includes copies of:

_____Entire Record	_____X-ray Reports	_____Progress Notes
_____X-ray Films	_____Physical Exam forms	_____MRI / Reports
	_____Daily chart notes	_____Other, specify: _____

Purpose for disclosure: _____ Treatment, Payment OR _____ Other (Specify) _____

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ **Email sent unencrypted to: _____
**I understand that records sent through unencrypted email pose a security risk but it is my requested method.

_____ Date: _____
Signature of Patient/Legal Representative/Relationship
(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)

Fees (check if applicable):

_____ $50 for entire medical records – Authorized Individual/Representative (mailed)
_____ $10 for entire medical records on USB – Patient
_____ No fee if fax/forward to medical office/facility

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.