CARROLL HEALTH GROUP

A LifeBridge Health Partner

Request for Medical Records Release

I authorize the release of my medical information from:

Carroll Health Group
193 Stoner Avenue, Suite 110
Attn: Medical Records
Westminster, MD 21157
Phone: 410-871-7074
Fax: 410-871-6227

Carroll Health Group Physician Office: _____

Records to be released to:

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 for personal use. Fees are assessed in accordance with Maryland State Law. One courtesy copy will be sent directly to the new physician of record.

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 Phone Number:_____

_____ _____
Patient/Guardian Signature Date