



Joseph K. Weidner, Jr., MD FAAFP • Barry O. Baker, Jr., PA-C • Ashley C. Cena, PA-C • Timothy E. Truman, DO
101 Colonial Way • Rising Sun MD 21911 • (410) 658-6696 F: (443) 393-7607
www.StoneRunFamilyMedicine.com

Date: _____

Request for Release of Medical Records

1 Patient Information:

Name: _____

DOB: _____ SSN: ****_*_*-_____

2 I request that the following medical records be released (check one):

_____ TO _____ FROM

Doctor/Facility Name

Address City State Zip

Phone Fax

3 Purpose of Disclosure:

- Changing Physicians
- Legal
- Continuing Care/Specialist Appointment
- Workers Comp
- Other (Please specify: _____)

4 Dates Requested:

_____ to _____
_____ All past dates
_____ Other (Please specify: _____)

I understand that this authorization will be valid for one year. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that if my record contains information related to substance abuse, HIV related information, and/or mental health information, that information will be released with my medical record.

Signature of Patient/Legal Guardian/Personal Representative

Date

If signed by anyone other than the patient, state the relationship and/or reason and legal authority to do so: