MedStar Harbor Primary Care

Medical Records Release Form

Last name:	First:	M.I.:
Addresss:		
City:	Zip:	Date of Birth:
Home phone:		
SSN:		
What is your preferred Method of communication?		
What is your preferred language?		

I authorize MedStar Harbor Primary Care to receive records from:

Name and phone number of the healthcare provider we are receiving records from:
Health information need: ☐ Labs ☐ Radiology ☐ Office Notes ☐ Entire Record ☐ Other (specific)_____

The protected health information may be disclosed to:

☐ Self	☐ Other
Name:	Name:
Address:	Address:
Phone:	Phone:

I understand that, as set forth in MedStar Harbor Primary Care Notice of Privacy Practices, I have the right to revoke this authorization in writing, at any time, by sending written notification to MedStar Harbor Primary Care.

Signature of patient: _____ Date: _____

Witness to signature: _____ Date: _____

Remarks: ☐ Urgent ☐ Patient in office

MedStar Harbor Hospital