Authorization to Release Medical Records

INSTRUCTIONS: If you are a patient requesting a copy of your own records, there is no fee. If patient records are requested by another provider, law firm or other third party, please submit a flat processing fee of $22.88, payable to Righttime Medical Care, with your request. Requests will be processed within 14 business days of receipt of the fee, if any, and the completed request form. Thank you.

Date of Request: _____

Patient Name: _____

Patient Date of Birth: _____

Date(s) of Service: _____

Location(s) of Visit: _____

I, the undersigned, request that a copy of your records regarding the above-named patient's visit to a Righttime Medical Care location on the above date(s) of service be provided to:

Name: _____

Relationship to Patient: _____

Street Address: _____

City, State, Zip: _____

Contact Number: _____

I agree that Righttime is not responsible for any action or adverse consequences related to the release of this information.

_____ _____

Signature Relationship to Patient

_____

Print Name

Mail or fax this completed form, along with applicable processing fee, to:

Righttime Medical Care
Medical Records Department
P.O. Box 6725
Annapolis, MD 21401
(443) 332-4387 (fax)