Release of Medical Information

ELMAN RETINA GROUP, P.A.

9114 PHILADELPHIA ROAD SUITE 310 BALTIMORE, MD 21237
7671 QUARTERFIELD ROAD SUITE 100 GLEN BURNIE, MD 21061
1838 GREEN TREE ROAD SUITE 170 PIKESVILLE, MD 21208
1001 PINE HEIGHTS AVE SUITE 102 BALTIMORE, MD 21229

PERMISSION TO OBTAIN MEDICAL RECORDS:

I, _____ with a date of birth, _____, give my permission to release my medical records to **ELMAN RETINA GROUP** so that he/she can better understand my condition and help me.

REQUESTING RECORDS FROM:

NAME OF PRACTICE

NAME OF PHYSICIAN

PHONE NUMBER

FAX NUMBER

ADDRESS

CHECK BOX

RECORDS WITHIN THE FOLLOWING TIME **PERIOD:**

- ☐ ALL RECORDS FOR THIS PATIENT
- ☐ RECORDS DATE BETWEEN AND

TYPE OF RECORDS:

- ☐ ANY AND ALL TYPES OF RECORDS YOU HAVE FOR THIS PATIENT
- ☐ **OTHER** (PLEASE SPECIFY:):

By putting my initials by each item below, I understand that I give permissions for records to be sent that may contain information about:

	MY MENTAL HEALTH
	TRANSMITTABLE DISEASE(S) I MAY HAVE LIKE HIV/AIDS
	GENETIC RECORDS
	DRUG AND ALCOHOL RECORDS

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PATIENT NAME: **DOB:**

I UNDERSTAND THAT:

- I do have to give my permission to share these records
- If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or staff person and sign a paper
- This form is only good for 1 year from the date I sign it

PATIENT'S SIGNATURE DATE:

AUTHORIZED REPRESENTATIVE'S SIGNATURE DATE:

RELATIONSHIP OF AUTHORIZED REPRESENTATIVE

PLEASE SEND RECORDS TO:

ELMAN RETINA GROUP

FAX NUMBER: **443-851-8502 OR 410-686-3690**

OR MAIL TO: **9114 PHILADELPHIA ROAD SUITE 310 ROSEDALE, MARYLAND 21237**

FOR ANY QUESTIONS CALL US AT **410-686-3000**