DR. JOSEPH K JAMARIS, LLC
300 HOSPITAL DRIVE #226
GLEN BURNIE, MD 21061-5707
410-768-4644

Authorization for Release of Medical Records

Patient Information

_____

_____

_____

_____

Date of Birth : _____

Social Security # : _____

Request Release from:

_____

_____

_____

_____

_____

_____

I hereby authorize you to release to _____ a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

_____ _____

Patient or Guarantor Signature Date

Please include the FOLLOWING ITEMS:

_____Admission notes

_____Discharge summary

_____Operative reports

_____EKG'S

_____X-ray reports

_____Progress notes

_____Pathology reports

_____Consultations notes

_____Laboratory tests

_____Stress tests

_____Other_____

Remarks : _____

This authorization will expire on _____.