

DUANE M. GELS, MD
129 Lubrano Drive, Suite 200
Annapolis, MD 21401
227 N Liberty Street
Centreville, MD 21617
Phone 410.573.1600 Fax 410.573.5841

www.annapolisallergy.com

Medical Records Release/Request Form

Instructions: This form must be fully completed before being accepted for processing. All fields must be completed – please use "N/A" where appropriate. hereby authorize Annapolis Allergy & Asthma or to disclose protected health information about me as described below. (name of provider to obtain necords from) Please send my medical records to: Fax them to: Annapolis Allergy & Asthma	Patient's Name			Patient's Date of Birth				
Annapolis Allergy & Asthma 129 Lubrano Drive, Suite 200 Annapolis, MD 21401 Centreville Location: 410-758-1982 Authorization expiration date:	hereby auth	norize	Annapolis Allergy & Asthma or		processing. A	all fields must be completed – please use "N/A to disclose protected health informati	A" where appropriate. I on about me as	
Authorization expiration date:	Please send my medical records to:			Fax them to:				
Authorization expiration date:	129 Lubrano Drive, Suite 200							
The specific information that should be disclosed is: Click Box to Date of Box to Service' Release Service' Release Of info. Service General This type Of	Studios (1905) Studios Action (1905) Action (1905) Action (1905) Action (1905)							
Box to Release This type Of info. Laboratory results Office Note History & Physical Pathology Office Note History & Physical I specifically request you include any of the following information if it exists: Psychiatric, alcohol/substance abuse, HIV/AIDS, Sexually transmitted disease or mental health. YES, include this information NO do not include information I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal privacy regulations. Your care will not be based on your willingness to authorize release of medical records. Purpose/use for the information isat the request of the individualtreatment other:								
Laboratory results Carry		Box to Release This type	Information Type	Date of Service/ General	Box to Release This type	Information Type	Date of Service. General	
Office Note History & Physical Other - please be specific (Body part			Laboratory results	Time frame			Time frame	
I specifically request you include any of the following information if it exists: Psychiatric, alcohol/substance abuse, HIV/AIDS, Sexually transmitted disease or mental health. YES, include this information NO do not include information I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal privacy regulations. Your care will not be based on your willingness to authorize release of medical records. You have the right to and may revoke this authorization by notifying allergyinfo@annapolisallergy.com in writing. However, the requestor understands that any action already taken based on this authorization cannot be reversed, and my revocation will not affect those actions. Purpose/use for the information is at the request of the individual treatment other:		0	Procedure Report please specify		0	CT/PET/MRI SCAN		
I specifically request you include any of the following information if it exists: Psychiatric, alcohol/substance abuse, HIV/AIDS, Sexually transmitted disease or mental health. YES, include this information NO do not include information I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal privacy regulations. Your care will not be based on your willingness to authorize release of medical records. You have the right to and may revoke this authorization by notifying allergyinfo@annapolisallergy.com in writing. However, the requestor understands that any action already taken based on this authorization cannot be reversed, and my revocation will not affect those actions. Purpose/use for the information is at the request of the individual treatment other:		0	Office Note History & Physical		0			
I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal privacy regulations. Your care will not be based on your willingness to authorize release of medical records. You have the right to and may revoke this authorization by notifying allergyinfo@annapolisallergy.com in writing. However, the requestor understands that any action already taken based on this authorization cannot be reversed, and my revocation will not affect those actions. Purpose/use for the information is at the request of the individual treatment other:		0	Pathology		0			
federal privacy regulations. Your care will not be based on your willingness to authorize release of medical records. You have the right to and may revoke this authorization by notifying allergyinfo@annapolisallergy.com in writing. However, the requestor understands that any action already taken based on this authorization cannot be reversed, and my revocation will not affect those actions. Purpose/use for the information is at the request of the individual treatment other:	I specifically request you include any of the following information if it exists: Psychiatric, alcohol/substance abuse, HIV/AIDS, Sexually transmitted disease or mental health. YES, include this information NO do not include information							
that any action already taken based on this authorization cannot be reversed, and my revocation will not affect those actions. Purpose/use for the information is at the request of the individual treatment other:	I understand	d that the in	nformation disclosed may be subject ons. Your care will not be based on y	to re-disclosure our willingness	by the perso to authorize	n or facility receiving it and would then no lo release of medical records.	onger be protected by	
	that any act	ion already	taken based on this authorization ca	annot be reverse	d, and my rev	ocation will not affect those actions. Purpos	uestor understands e/use for the	
					Date of Signature:			