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

Patient's Name_____ Patient's Date of Birth_____

Instructions: This form must be fully completed before being accepted for processing. All fields must be completed – please use "N/A" where appropriate. I hereby authorize ____ Annapolis Allergy & Asthma or_____ to disclose protected health information about me as described below. (name of provider to obtain records from)

Please send my medical records to:

Annapolis Allergy & Asthma
129 Lubrano Drive, Suite 200
Annapolis, MD 21401

Fax them to:

Annapolis Location: 410-573-5841

Centreville Location: 410-758-1982

Authorization expiration date: _____, OR when the following event occurs: ___ 1 year from date of signature.

The specific information that should be disclosed is:

Click Box to Release This type Of info.	Information Type	Approx. Date of Service/ General Time frame	Click Box to Release This type of info.	Information Type	Approx. Date of Service. General Time frame
○	Laboratory results		○	X-ray (Body part_____)	
○	Procedure Report please specify _____		○	CT/PET/MRI SCAN (body part_____)	
○	Office Note History & Physical		○	Ultrasound (Body part_____)	
○	Pathology		○	Other – please be specific (_____)	

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: _____

Patient Signature: _____ Date of Signature: _____