www.laurelmedicine.com

Release of Information Form (Incoming)

I, _____ request that my medical records be forwarded to Laurel Medical Associates as outlined below. Please mail or fax to the address below.

( ) All medical records, diagnostic and labs

( ) Last 3 months of medical records

( ) Labs and diagnostic tests

( ) Hospital discharge, admission notes, imaging studies _____

_____

( ) Other: _____

Name of Hospital or Physician Office you want your Records transferred from:

Name: _____

Address: _____

Phone #: _____

Please mail or fax to:

Laurel Medical Associates
13635 Baltimore Avenue
Laurel, Maryland 20707

Fax#: (888) 371-0437

_____

Name Signature of Authorized Representative Date

Updated 08/17/2015