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#: (301) 497-0402

____

Name | Signature of Authorized Representative | Date

Confidentiality Notice: The medical and/or personal information in this fax message is confidential and protected by both state and federal law. Unauthorized persons must not review, copy, disclose, or disseminate such information. If you are not the intended FAX recipient or the intended recipient's agent, you have received this fax in error-please do not review or further disclose the information contained in this fax. If you have received this fax in error, please notify us immediately at the telephone number indicated above and either destroy these documents or return the originals to us by mail. Thank you.

Updated 01/17/2020