Mary's Center
Request for/Release of Medical Records Form

Date: _____

FOR OFFICE USE ONLY	
_____ Authorized Staff Signature	_____ Date
_____ Name	_____ Title

_____ Patient name

_____ Date of Birth

_____ , _____ Are you registered under a different name?

I receive my primary medical care at the Ontario / Kennedy / Maryland .(Please circle one)

I authorize the release of my information from:

☐ Mary's Center
2333 ONTARIO ROAD, NW
Washington, DC 20009
Tel: (202) 483-8196
Fax (202)545-2069

☐ Mary's Center
3912 GEORGIA AVE., NW
Washington, DC 20011
Tel: (202) 545-8019
Fax (202)545-2070

☐ Mary's Center
8709 FLOWER AVENUE
Silver Spring, MD 20901
Tel: (240)485-3160
Fax (240)485-3190

☐ Mary's Center
8908 RIGGS ROAD
Adelphi, MD 20783
Tel: (301)422-5900
Fax (301)422-5935

to the following person/facility:

☐ _____
_____
_____
Tel: ( ) _____
Fax: ( ) _____

The purpose for utilizing or disclosing my personal health information is:

_____

Information to be released (please check all that apply):
NOTE: Authorizations for the use and disclosure of behavioral health records require a different form.

☐ Progress Notes……All / From: _____ To: _____
☐ Diagnostic & Lab Test Results……..All / From: _____ To: _____
☐ Social Work Notes……All / From: _____ To: _____
☐ Vaccination Record……...All / From: _____ To: _____
☐ Other: _____

By signing below, I attest that I have read and understand the information above. I may nullify this authorization (in writing) at any time unless Mary's Center has already taken action based on this form (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest the policy or claim under the policy). I understand that information disclosed based on this authorization may be re-disclosed by the entity or the person who receives the information. I understand it is possible that the information no longer will be protected under federal medical privacy law. I may refuse to sign this authorization and will not result in Mary's Center denying me treatment. I may inspect or copy the protected health information to be used or disclosed. The use or disclosure of the requested information may result in the direct or indirect payment to Mary's Center from a third party, including copying fees.

_____ Name

_____ Signature

_____ Relationship to Patient

_____ Phone

Mary's Center
Request for/Release of Medical Records Form

Date: _____

FOR OFFICE USE ONLY	
_____ Authorized Staff Signature	_____ Date
_____ Name	_____ Title

_____ Patient name | _____ Date of Birth | _____, _____ Are you registered under a different name?

I authorize the release of my information from the following person/facility:

_____
_____
_____
Tel: ( ) _____
Fax: ( ) _____

to the following person facility: (Please check one)

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_____ Name | _____ Signature

_____ Relationship to Patient | _____ Phone