Annapolis cardiology consultants, LLC
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To:

_____
Name of Healthcare Provider/Physician/Facility/Medical Contractor

_____
Street Address

_____
City, state and Zip code

Re:

Patient Name:_____

Date of Birth:_____ Social Security Number:_____

I authorize and request the disclosure of all my medical records. Meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinical records, treatment plans, admission records, discharge summaries, request for and reports of consultations, documents, correspondence, test results, diagnostic results, laboratory results, questionnaires/histories, correspondence, ad records reviewed by other medical providers.
I understand that the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

You are authorized to release the above records to the following physicians office:

Annapolis Cardiology Consultants
2002 Medical Parkway, Suite 310
Annapolis, MD 21401

I understand the following:

a. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Name and Relationship of Legally Authorized Representative to Patient

_____ _____
Witness Signature Date