HUB CITY Family Practice LLC

19426 Leitersburg Pike
Hagerstown, MD 21742
Phone: 240-513-6330
Fax: 240-513-6332

AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I hereby authorize the release of my medical records by the following organization or physician listed below:

Practitioner's Name: _____

Practitioner's Street Address: _____

City:_____ State:_____ Zip:_____

Practitioner's Phone #: _____ Fax # of Practitioner: _____

Reason for Records Release: _____

_____

These records are to be mailed or faxed to:
Hub City Family Practice, LLC
19426 Leitersburg Pike
Hagerstown, MD 21742
Fax: 240-513-6332

Patient's Name: _____ Birthdate: _____/ _____/ _____

Street Address: _____

City:_____ State:_____ Zip:_____

Phone#: _____

The type and amount of information to be disclosed is indicated as follows: (specify dates where appropriate)

☐ X-Ray films (Specify type/date) _____ ☐ Laboratory results ☐ Immunizations

☐ Genetic testing, if any _____ ☐ Most recent 3 years of Records

☐ Entire Medical Record ☐ Other _____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

_____ _____/ _____/ _____
Patient / Guardian Signature (relationship to patient) or Power of Attorney Date

Print Name: _____