

# REQUEST FOR MEDICAL RECORDS

In the State of Maryland the Physician who creates and maintains the patient's medical records is the owner of those records. Currently, Maryland Law states that a photocopy of a medical record maybe released to the patient upon proper request within a reasonable amount of time. "Proper request" means a written request signed by the patient, or in the case of a minor, the legal guardian of the patient. The form below maybe used for this purpose. For reasons of medical liability, copies of medical records forwarded to this office from other providers become property of this office and must remain in your records here. If you wish to obtain copies of your medical records from those providers, you must contact them directly.

Please note that the law allows the Physician a "reasonable period of time" to comply with your request. It also permits the office to charge a reasonable fee for preparing the copies.

**Patient's Name and address** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
\_\_\_\_\_ **Phone #** \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize release of copies of my medical records.

## TO:

\_\_\_\_\_ Myself or my representative. \_\_\_\_\_.

\_\_\_\_\_ The following Physician or Medical office.

**Physician's name and address.** \_\_\_\_\_

\_\_\_\_\_

**Physician's telephone #** \_\_\_\_\_

## From:

\_\_\_\_\_ The following Physician's or medical office.

**Physician's name and address.** \_\_\_\_\_

\_\_\_\_\_

**Physician's telephone #** \_\_\_\_\_

**Signature of Patient or Guardian.** \_\_\_\_\_ **Date:** \_\_\_\_\_