Authorization to Release Medical Records

INSTRUCTIONS: You may obtain a free copy of your medical records and billing statements by visiting the patient portal at www.myrighttime.com or calling 888.808.6483. For all other requests, including third party requests, law firm and form completion, a fee may apply. Requests will be processed within 10-15 business days of receipt of payment. Thank you.

Patient Name: ______________________________ Date of Birth: ______________________________

Date(s) of Service: ______________________________ Location(s) of Visit: ______________________________

I, the undersigned, request that a copy of your records regarding the above-named patient's visit to a Righttime Medical Care location on the above date(s) of service be provided to:

Name: ______________________________

Relationship to Patient: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Contact Number: ______________________________

Fax Number: ______________________________

I agree that Righttime is not responsible for any action or adverse consequences related to the release of this information.

______________________________ ______________________________
Signature Relationship to Patient

______________________________ ______________________________
Print Name Date

Mail or fax this completed form to:

Righttime Medical Care
Medical Records Department
P.O. Box 6725
Annapolis, MD 21401
Fax: (443) 332-4387

❑ **I prefer to pay via credit card (you will be contacted by phone)**

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