Authorization to Release Medical Records

INSTRUCTIONS: If you are a patient requesting a copy of your own records, there is no fee. If patient records are requested by another provider, law firm or other third party, please submit a flat processing fee of $22.88, payable to Righttime Medical Care, with your request. Requests will be processed within 7 to 10 business days of receipt of the fee, if any, and the completed request form. Thank you.

Date of Request: _____

Patient Name: _____

Patient 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: _____

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

Mail or fax this completed form, along with applicable processing fee, to:

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