Carlden Health Family Clinic
198 Thomas Johnson Drive
Suite# 103
Frederick, MD 21702

Dorcas (Dee) Acheampong, FNP
OFFICE (301) 447-0710
FAX (301) 447-0771

Request For Medical Records

I AUTHORIZE:

Doctor: ______________________________

Facility: ______________________________

Phone: ______________________________

Fax: ______________________________

TO RELEASE RECORDS TO:

Carlden Health Family Clinic
198 Thomas Johnson Drive
Suite# 103
Frederick, MD 21702
info@carldenhealth.com
Phone: 301-447-0710
Fax: 301-447-0771

Check all that apply. If nothing fits your reason for transferring your records, please provide additional information in the "other" section. You may write in the margins, if necessary.

Reason For Release:

- ☐ Transfer Records From Previous PCP
- ☐ Transfer Records From A Specialist
- ☐ Transfer Records From A Hospital
- ☐ Keep Records On File At Family Care
- ☐ Other: ______________________________

Records To Be Released:

- ☐ All Records
- ☐ Office Visits
- ☐ Physical Exams
- ☐ Imaging / Radiology / Lab Results
- ☐ Other: ______________________________

Information NOT Authorized For Release:

- ☐ Alcohol / Drug Abuse Notes
- ☐ STD / HIV Results
- ☐ Mental Health Records
- ☐ Other: ______________________________

I request that information about my healthcare and treatment be released as set forth on this form. This authorization covers all records that I have indicated above for release, and only those records. This authorization covers information related to alcohol and drug abuse, mental health treatment, and sexually transmitted diseases, unless otherwise indicated. I have the right to revoke this authorization at any time by signing a written statement. This authorization will expire 365 days after the date I have signed below, unless otherwise indicated. I understand that this authorization is voluntary. I understand that a charge may apply for these medical records and may be payable to the facility that is releasing the information under MD Statute 4-304.

Please complete the FOUR demographic details below for the specified patient indicated in this release.

______________________________ 1. Patient's Signature

______________________________ 3. Today's Date

______________________________ 2. Patient's Printed Name

______________________________ 4. Patient's Date of Birth

Optional: Expiration Date of Signed Release (Default is 365 days):__________/_________/ ___________