Alpana Goswami, M.D.
11125 Rockville Pike, 110
Rockville, MD 20852
Tel: 301-984-3100 • Fax: 301-984-3130

Authorization for Release of Medical Records

Patient Information

Name: _____
(Last) (First) (M)

Date of Birth: _____

Social Security Number: _____

Request Release from:
Doctor/Facility/Hospital: _____
Address:
_____

_____

Phone: _____ Fax: _____

I hereby authorize you to release to _____ a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

_____ _____
Patient or Guarantor Signature Date

Please include the FOLLOWING ITEMS:

_____ Admission notes

_____Progress notes

_____Discharge summary

_____Pathology reports

_____Operative reports

_____Consultations notes

_____EKG'S

_____Laboratory tests

_____ X-ray reports

_____Stress Tests

_____ Other _____

Remarks:_____