AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby give permission to release my medical file

Check One: To/From

Drs. Branton & Jarrah, PA
1205 Pemberton Drive, Ste:101
Salisbury, MD 21801
Phone 410-546-5141
Fax 410-548-7574

Check One: To/From

____
Person/Facility Name
____
Street Address
____
City State Zip
____
Phone Fax
____

I understand that there is a fee for copying and handling all records not intended for continued patient care. I understand that all fees have been prepared in compliance with applicable Maryland State guidelines. By signing this authorization, I agree to pay these fees before receiving my medical records. This authorization is valid for one year from the date signed.

PLEASE READ CAREFULLY AND COMPLETE ALL ITEMS ON THIS AUTHORIZATION THAT APPLY.

Patient Name ____

Address____

City________________________________ State _____________ Zip _____________

Phone____________________________ Social Security#:XXX-XX-________ DOB________

Patient Signature____ Date________________

Information to be release: All Records_______ Office Notes_______ Lab Results_________

X-ray Reports________ Other________

Please Specify____

Reason for Disclosure: Transferring Medical Care_________ Moving________

Continuity of Care________ Disability_________ Lawyer________ Insurance________