THE CAMALIER BUILDING, SUITE 506 · 10215 FERNWOOD ROAD · BETHESDA, MD 20817 · TEL (301) 530-1010 · FAX (301) 897-8597

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize OrthoBethesda and/or OrthoBethesda Physical Therapy Services to release records to:

□ Myself
□ The following person/organization:

Name	Phone
Street Address	Fax
City, State, Zip Code	E-mail

Records to be released using: □ Fax □ Mail □ Secure E-mail □ Office pick-up on _____

*****PLEASE ALLOW 2-4 BUSINESS DAYS TO PREPARE*****

□ Office Visit Notes □ Operative Reports □ Diagnostic Studies from Outside Facilities	□ Physical Therapy Records □ X-ray CD ($10.00) □ X-ray images (print or digital) □ Itemized Billing Statement

Treating Physician	Body Part	Dates of Services

Patient Information:

Name	Date of Birth
Daytime Phone Number	Signature Date

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire one year from the date of my signature, unless I revoke the authorization prior to that time.