

Warner & Van Meter, M.D., P.A.
63 Thomas Johnson Dr., Suite A
Frederick, MD 21702
PH (301)663-0400
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Medical Records Release Form

From: Warner & Van Meter, M.D., P.A.
63 Thomas Johnson Dr, Ste A
Frederick, MD 21702

Patient's Name: _____ Date of Birth: _____

Recipient: _____ Reason for Request: _____

A copy or summary of the following records is requested for release to the person/company stated above:

- Complete Medical Record
- Biopsy Report(s)
- Lab Report(s)
- Consultation Reports
- Medication Allergies
- Allergy Test/Treatment
- Surgical Procedures
- Other _____

For dates of service from _____ to _____

I request the records be sent in the following format (select one):

- Disc
- Flash drive
- Hard copy (paper)

Send records to (select one):

- Fax Number: _____
- Address: _____
- Email: _____

You have the option to request your records be electronically mailed (emailed). However, please be advised that email communication can be intercepted in transmission or misdirected. We follow guidelines that help to minimize the risk of a breach of privacy, but they do not eliminate that risk. We recommend you consider communicating any sensitive information by telephone, fax or mail. By signing below, you acknowledge such risks should you request your records be submitted in this manner.

Patient Signature

Date

MD Statutory Copying Fee: _____
Preparation Fee: _____
S/H (If applicable): _____
Total: _____

Method of payment:

- Credit Card Check
- Money Order Cash

Prepared by: _____

OK to release

Doctor's signature: _____