LYNCH PRIMARY CARE, LLC
31 E. Lee Street
Bel Air, MD 21014
Lynchprimarycare.com

P: 410-638-5339
F: 410-638-8877

AUTHORIZATION to RELEASE MEDICAL RECORDS

I, ______________________________, authorize the release of my medical records from the

office of ____

____

____

To be sent to: Lynch Primary Care
31 E. Lee Street
Bel Air, MD 21014

Upon receipt of this document, please send the following information:

____ Problem List
____ Medication List
____ Office Notes (past year)
____ Discharge Summaries
____ Cardiac Procedures
____ Dexa Scans (last 2)
____ Consultation Notes (past 5 yrs)
____ History & Physical (most recent)
____ Laboratory Data (past 2 yrs)
____ X-ray Reports (past 5 yrs)
____ Pathology Reports

I am aware that these records may contain information relating to psychiatric or psychological testing or treatment, biofeedback training and/or alcohol/drug abuse.

This consent is subject to written revocation by the undersigned at any time, except to the extent that action has been taken, and if not earlier revoked, this consent shall become invalid six months from the date of signature.

I understand that I have the right to receive a copy of this authorization upon my request.

PATIENT SIGNATURE: ______________________________ **DATE:** ____________

PATIENT NAME (Please print): ______________________________________

PATIENT DATE OF BIRTH: ______________________________________