



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 the following provider/facility:

_____	_____
Provider/Facility	Phone
_____	_____
Street Address	Fax
_____	_____
City, State, Zip Code	E-mail

To release my medical records:

Notes (body part, date, doctor, kinds of reports/imaging—surgical, MRI, EMG, etc)

To OrthoBethesda.

ATTN: Medical Records, 10215 Fernwood Road, Suite 506, Bethesda MD, 20817
Phone: 240-482-2418 Fax: 301-897-8597 Fax 2: 301-530-3476
Email: medrecords@bcc-ortho.com

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.