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 Aligned Orthopedic Partners (OrthoBethesda).
ATTN: Medical Records, 10215 Fernwood Road, Suite 506, Bethesda MD, 20817
Phone: 301-530-1010 extension 2420 or 2418 Fax: 301-897-8597 Fax 2: 301-897-8105
Email: medicalrecordsOB@AlignedOrtho.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.