Metropolitan Women's Group, LLC
Obstetrics and Gynecology

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MEDICAL RECORDS RELEASE FORM

Dear Patient,

In the State of Maryland, the physician who creates the patient's medical record is the owner of those records. Maryland law (Health General Section 4-304) and the Federal Health Insurance Portability and Accounting Act (HIP AA) of 1996 allows physicians to charge patients (or the patients "personal representative") a fee for copying medical records. The charges are adjusted annually in accordance with the Consumer Price Index. The 2013 fee is calculated to include the following:

- ***Fee for copying not to exceed $0.76 cents for each page of the medical record.***
- ***The actual costs of postage and handling.***
- ***Preparation fee of $22.88, if the records are to be sent to another provider or health insurance carrier.***
- ***The Federal HIPAA regulations do not allow a charge for a preparation fee for records provided directly to the patient.***
- ***Retrieval fee will apply if records are in storage off-site. A minimal charge of $14.95 for up to 25 pages; $0.15 cents for each additional page thereafter.***

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/ facility/entity listed below.

Patient Name:_____ Date of Birth:_____

Address:_____ Last 4 SS#:_____

The information you may release subject to this signed release form is as follows:
() Complete Records ()History & Physical ()Progress Notes ()Radiology Reports
()Pathology Reports ()Lab Reports ()Operative Reports
()Hospital Reports ()Treatment Record ()Other (please specify below)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name:_____ Address:_____
Phone #:_____ Fax#: _____

The purpose/reason for this release of information is as follows: _____

I understand that the medical records to be released may contain information related to HIV status, AIDS, sexually transmitted diseases, alcohol and/ or drug use, or mental health services and I hereby authorize the release of this information.

Patient Signature or Authorized representative: _____

Date: _____

OFFICE USE ONLY

Date Records Sent:_____

Employee Name:_____

()Mailed () Faxed

() Printed and picked up