

**HomeCall RXPRESS**  
10200 Old Columbia Rd  
Columbia MD 21046

**HomeCall Pharmaceutical Services**  
10200 Old Columbia Rd., Suites M & N  
Columbia, MD 21046

### MEDICAL RECORDS RELEASE FORM

I, \_\_\_\_\_, \_\_\_\_\_, hereby  
(your name) (your phone number)

give permission to the above agency to release the medical records of:

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Social Security # \_\_\_\_\_

Covering the period of care from \_\_\_\_\_ to \_\_\_\_\_

This record may include information about serious communicable diseases and/or infections as defined by the public health rules, which include Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), venereal disease and tuberculosis, if any; alcohol and/or drug abuse information protected under the regulations of 42 CFR Part 2, if any; psychiatric/psychological records, if any; social work records, if any; including communications made by the patient to a social worker, psychiatrist, or psychologist.

#### Records to be Released

Complete Medical Record       Discharge Summary  
 Initial Assessment (s)       Medication Profile  
 Care Plan/Plan of Care       Lab Reports  
 Clinical/Progress Notes       AIC Visit Notes      Other Please Specify \_\_\_\_\_

#### Purpose of Disclosure

Continuation/coordination of care (give MD name): \_\_\_\_\_  
 Insurance billing verification (give company name): \_\_\_\_\_  
 Other (please specify) \_\_\_\_\_

#### Records to be Released to:

Name of person or institution \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

I understand that this permission is voluntary and may be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization will automatically terminate 30 days following completion of the intended purpose of disclosure (ex: legal uses, billing). I understand that if the entity authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulation. (Refer to Privacy Notice for information on how to revoke this authorization.)

This information may potentially be redisclosed by the recipients and no longer covered by the privacy laws. The organization, its employees, and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Signature of Person in Interest:

\_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_