MEDICAL RECORDS RELEASE

Rochelle S. Hardy, M.D. 7404 Executive Pl, Suite 502, Lanham, MD 20706
PHONE# (301) 249-2700 FAX# (301) 249-4559

I, _________________________, hereby authorize the release of any and all medical records relating to my care during the period of ____________ to _______________.

PATIENT'S NAME: ____

DATE OF BIRTH:_________________ **PHONE**:(_____) _______-_________

ADDRESS:____

CITY:___________________________ **ST**:_________ **ZIPCODE:**___________

SIGNATURE:_________________________ **TODAYS DATE:**____________

PLEASE CHECK ONE OF THE FOLLOWING:

☐ 1. **PLEASE SEND MY MEDICAL RECORDS TO DR. HARDY FROM**:

Dr/Hospital: ____

Address ____

City ______________________ **St** _____________ **Zip** ______________

Phone(______) ________-_________ **Fax** (______) ________-_________

☐ 2. **PLEASE SEND MY MEDICAL RECORDS FROM DR. HARDY TO**:

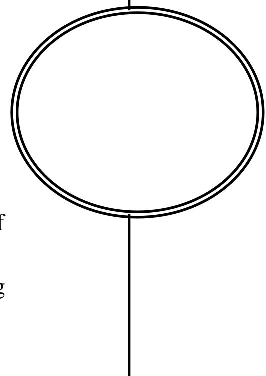
Dr/Hospital: ____

Address ____

City ______________________ **St** _____________ **Zip** ______________

Phone (______) _______-_________ **Fax** (______) ________-_________

☐ 3. **PLEASE RELEASE MY MEDICAL RECORDS TO MYSELF** (there is a **minimum fee** of **$25** for medical records).



This facsimile contains PRIVILEGED AND CONFIDENTIAL INFORMATION contended only for the use of Addressee (s) named above. If you are not the intended recipient of this facsimile, the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination or copying of the facsimile is strictly prohibited. If you have received this facsimile in error, please notify us by telephone and return the original facsimile to us at the above address. Thank you.