LYNCH PRIMARY CARE, LLC
615 W. MacPhail Road, Suite 212
Bel Air, MD 21014
Lynchprimarycare.com

P: 410-638-5339
F: 410-638-8877

AUTHORIZATION to RELEASE MEDICAL RECORDS

I, _____, authorize the release of my medical records from the office of _____

_____

_____

To be sent to: **Lynch Primary Care**
615 W. MacPhail Road, Suite 212
Bel Air, MD 21014

Upon receipt of this document, please send the following information:

_____ Problem List
_____ Medication List
_____ Office Notes (past year)
_____ Discharge Summaries
_____ Cardiac Procedures
_____ Dexa Scans (last 2)
_____ Consultation Notes (past 5 yrs)
_____ History & Physical (most recent)
_____ Laboratory Data (past 2 yrs)
_____ X-ray Reports (past 5 yrs)
_____ Pathology Reports

I am aware that these records may contain information relating to psychiatric or psychological testing or treatment, biofeedback training and/or alcohol/drug abuse.

This consent is subject to written revocation by the undersigned at any time, except to the extent that action has been taken, and if not earlier revoked, this consent shall become invalid six months from the date of signature.

I understand that I have the right to receive a copy of this authorization upon my request.

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT NAME (Please print): _____

PATIENT DATE OF BIRTH: _____