True Physician Care, LLC
10215 Fernwood Road, Suite 405
Bethesda, Maryland 20817

MEDICAL RECORDS REQUEST

Patient Information

Name: DOB: Last 4 digits of SSN:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

Where are we sending the records?

Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

What would you like released?

□ All Records □ Office/Clinic Notes □ Operative Reports
□ Lab/Pathology Results □ Radiology Reports □ Immunization Records

□ Dates_____to_____ □ Other _____

Why are we sending the records?

□ Personal Use □ Litigation/Legal □ Insurance □ Transfer of Care

****Per HIPAA 45 CFR 164.524, you may be charged a reasonable fee for reproducing medical records.*
*Fees are non-refundable once services are rendered. Payment is due on receipt of invoice, prior to records being sent.****

How would you like the records sent?

☐ Email ☐ Fax ☐ Mail (postage fees may apply)

Patient's Signature

I hereby authorize True Physician Care, LLC to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

Patient's Signature: Date:

Relationship to patient: _____