TRUNG HOA PHAM, MD, LLC
Diplomate of the American Board of Internal Medicine

Authorization For Release Of Medical Records

Patient Information:

_____

_____

_____

_____

Date Of Birth: _____

Request Release To:

_____

_____

_____

_____

SSN: _____

I hereby authorize you to _____ a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

_____ _____

Patient or Guarantor Signature Date

Please include the following items:

_____ Admission Notes
_____ Discharge Summary
_____ Operative Reports
_____ EKG's
_____ X-Ray Reports
_____ Progress Notes

_____Pathology Reports
_____ Consultations Notes
_____ Laboratory Tests
_____ Stress Tests
_____ Other _____

Remarks: _____

This authorization will expire on: _____

5415 Old Court Road, Suite 102 | Randallstown, MD 21133 | Phone: (410) 701-4600 | FAX: (410) 701-4481