UNIVERSITY of MARYLAND
ORAL-MAXILLOFACIAL
SURGERY ASSOCIATES, P.A.

650 W. Baltimore Street, Suite 1401
Baltimore, MD 21201
410-706-6195

RECORDS RELEASE REQUEST

Date: _____ Duplication Fee (Office Use Only): _____

Patient Name (please print): _____ Patient Date of Birth: _____
First M.I. Last mm/dd/yyyy

Chart Number (Office Use Only): _____

As required by the Health Insurance Portability and Accountability Act of 1996, UMOMSA may not use or disclose your health information without your authorization except as provided in our Notice of Privacy Practices. Your signature on this form indicates that you are giving permission for the uses and disclosures described below.

If other than patient, print the name of the person requesting release of records on behalf of the patient named above, and specify relationship to patient.

Requestor's Name: _____ Relationship to patient: _____
First M.I. Last

By signing below I give permission to UMOMSA to release copies of (check one):

☐ My records ☐ My child's records ☐ The records of the patient name above whom I am legally authorized to represent

I authorize and request the records to be released/sent to (please print):

Name: _____

Address: _____
Street City State Zipcode

I understand that:

- I have the right to request a copy of this form after I sign it, as well as inspect or copy any information to be used and/or disclosed under this authorization.
- If the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- A copy of the patient record will be released. The original patient record remains the property of UMOMSA and will be maintained in accordance with Maryland state laws.
- I will be charged a fee for duplication of the information.

I authorize and request the release of the following information (please check):

Medical record (treatment notes, treatment plan(s), biopsy results and prescriptions)
☐ Last 2 years
☐ Full history

Copies of dental xrays
☐ Last 2 years
☐ Full history

Patient financial history
☐ Last 2 years
☐ Full history

Medical history
☐ Current
☐ Full history

Photographs and Other Images
☐ Last 2 years
☐ Full history

Processing your request for copies of records and radiographs (xrays) takes approximately ten (10) working days after receipt of the authorization form and payment. **Please make check payable to UMOMSA and send to the attention of Kristin Wright, Records Coordinator. To reach us by telephone, call 410-706-6195 or fax to 410-706-4199.**

Patient or Requestor's Signature **Date**