HOWARD COUNTY
Direct Primary Care

Request for Medical Records

1) **PATIENT INFORMATION:**

_____

Name Address City State Zip

_____ (_____)_____ _____

Date of Birth Daytime Phone Previous Name

2) **AUTHORIZES:**

_____

Name of Health Care Provider /Plan / Other

_____

Address

3) **TO DISCLOSE TO:**

Howard County Direct Primary Care/Dr. Orsolya Polgar

_____

Name of Health Care Provider / Plan / Other

8895 Centre Park Drive, Suite E, Columbia, MD 21045 ***(443) 864-5507***

_____

Address Fax Number

4) **DATE(S) OF INFORMATION TO BE DISCLOSED**: From _____ to _____ If left blank, information from the past two (2) years is requested. (month/year) (month/year)

5) **INFORMATION TO BE DISCLOSED:**

- ☐ All medical records related to (specify condition, treatment, etc.): _____
- ☐ All medical records:
- ☐ Radiology films/images (specify test): _____
- ☐ Specific records/information as follows: _____

_____

_____

6) **PURPOSE:** Further Medical Care

SIGNATURE OF PATIENT / LEGAL REP: _____ DATE: _____