Frederick Internal Medicine and Endocrinology Services

ENDOCRINOLOGY
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INTERNAL MEDICINE
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS PROCESSING FEE

To request patient medical records both pages need to be completed and signed and either mailed faxed, or hand delivered to:

Address FIMES, Medical Records Dept
65 Thomas Johnson Dr
Suite C
Frederick, MD 21702

Fax: 833-979-0962

FIMES has partnered with CIOX to process and fulfill your request for a copy of your medical record. The fees charged for copying and mailing these records are set by state law.

STATE OF MARYLAND RATES: $22.88 Preparation Fee & $0.76 per page for patients

By signing below, I acknowledge that I am aware of the fee that will be billed to me for requesting a copy of my medical record. I agree to pay this fee when services are rendered and I receive and invoice from CIOX.

_______________________________________ Date of birth ____/____/____
Print Patient Name

_______________________________________ Date ____/____/____
Signature of patient or legal representative

Relationship to patient ______________________________

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT IDENTIFICATION	Name ______________________ Date of birth ___/___/___ SSN xxx-xx-_ _ _ _ Address ____________________ City ________________ State ____ Zip ______ Phone ________________ Work/Cell phone ________________
WHERE RECORDS SHOULD BE SENT?	Name ______________________ Address ____________________ City ________________ State ____ Zip ______ Phone ________________
PURPOSE OF RECORDS	☐ Referral to specialist ☐ Insurance ☐ Workers Comp ☐ Leaving Practice ☐ Legal Investigation ☐ Disability ☐ Personal Records
WHAT INFORMATION DO YOU WANT?	******* **SEE DIRECTIONS FOR FEES THAT MAY APPLY** ******* ☐ **Abstract** (only records needed to continue your care) ☐ **Legal medical chart** ☐ **Billing Records** ☐ **Specific records** ________________________________ **Dates of treatment to be released: from** ___/___/___ **to** ___/___/___
AUTHORIZATION	**I understand that** my medical record my include information on diagnosis or treatment related to psychiatric or psychological conditions, drug or alcohol abuse, and AIDS or HIV. _____**I do** / _____**I do not** authorize release of such information **(initial only one)** **I understand that** • I may refuse to sign this authorization which will not affect my treatment • I understand that there is a $22.88 preparation fee, as well as a fee of $0.76 per page • I may take back this authorization in writing, except for any actions already taken based upon it • This authorization will expire when the records are released or 12 months from the date of your signature, whichever comes first. • If the records are not sent to a health plan or health care provider, the released information may no longer be protected by federal privacy rules and may be shared with others ______________________________ Signature of patient or legal representative Date ___/___/___ Relationship to patient ______________________