Lev Tomashevsky DDS LLC
Robert J. Kelly DDS & Associates

Medical Records Release and
Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____

I authorize the custodian of records to disclose/release the following information (Check all applicable):

☐ All records
☐ Laboratory/pathology records
☐ X-ray/radiology records
☐ Billing records
☐ Abstract/Summary
☐ Pharmacy/prescription records
☐ Other _____
_____

Please send the records listed above to (use additional sheets if necessary):

Name: _____

Address: _____

Phone: _____ Fax: _____

This authorization shall expire no later than: _____ and may not be valid for greater than one year from the date of signature for Maryland medical records.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____
Signature of patient

_____
Printed name of patient