Medical Records Release Authorization

Drs. Poulton & Smith, LLC
5233 King Ave
Suite 204
Baltimore, MD 21237
Phone: 410-574-3100
Fax: 410-686-5036

I hereby authorize and request :

Name of sender/Organization:_____

Street Address:_____
City/State/Zip:_____
Phone Number:_____
Fax Number:_____

Release to:

Drs. James K. Poulton
5233 King Ave
Suite 204
Baltimore, MD 21237
410-574-3100
410-686-5036

Thomas F. Smith M.D.
5233 King Ave
Suite 204
Baltimore, MD 21237
410-574-3100
410-574-3710

Please forward the complete history and records in your possession concerning my illness and/or treatment from (Please check one)

- o **Date**_____**to**_____
- o **All records**

Reason for request:
Change of Insurance
Change of Physician
Moving
Other:_____
I understand that a reasonable fee may be charged for duplication of records.

Print Name: _____ Date of Birth: _____
Social Security Number: _____
Address: _____
Daytime Phone Number:_____
Signature:_____Date:_____
Relationship to Patient if minor:_____