Poolesville Family Practice **Amar Duggirala, DO, MPH***

***Certified, American Board of Family Medicine**

Request for Medical Records

To: _____

Name of Health Care Provider (Print or Type)

_____

Address

Re: _____

Name of Patient (Print or Type)

_____ _____

Date of birth Today's Date

The information covered by this authorization includes (all medical records, unless otherwise stated):

_____

Purposes of Disclosure

Information listed above will be disclosed for the purpose of **continuing medical care.**

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by **Poolesville Family Practice**

Expiration Date of Authorization

This authorization is effective through ___/___/___ unless revoked or terminated earlier by the patient or the patient's personal representative.

Rights of the Individual

You may inspect or copy information used or disclosed under this authorization.

You may refuse to sign this authorization.

Effect of Refusing Authorization:

If you refuse to sign this authorization, Dr. Duggirala will not deny you any treatment of any kind.

_____

Name of Patient (Print or Type)

_____ _____

Signature of Patient Date

_____

Signature of Patient Representative (if patient is a minor or unable to sign for themselves)

_____

Relationship of Patient Representative to Patient (if applicable):

19710 Fisher Ave., Ste J, Poolesville MD 20837•(301) 972-7600•Fax (301) 972-8006