

ALLISON LINQUIST, MD PC

**6518 Meadowridge Road, Suite 106
Elkridge, Maryland 21075
(443) 393-0223 Fax: (443) 393-0215**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION: (Please print)

Name: _____

Date of birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Please release a copy of all medical records, including but not limited to progress notes, operative notes, laboratory results, and diagnostic test from:

Clinic name: _____

Telephone number: _____ Fax number: _____

TO

Allison Linquist, MD PC
6518 Meadowridge Road, Suite 106
Elkridge, Maryland 21075
443-393-0223
Fax: 443-393-0215

Please send medical records no later than: _____

BY MY SIGNATURE I AUTHORIZED RELEASE OF MY MEDICAL RECORDS:

Patient Signature: _____ Date: _____

** If you are a former patient of Dr. Linquist's please complete this form and fax it to Anne Arundel Dermatology, P.A. at (410) 582-9155, Attn: Medical Records Department.