Maryland Digestive Disease Center

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병원 기록 공개 Records Release

To: ____

(Physician or party you wish to get records from 환자분의 기록 공개를 의뢰하고 싶은 곳)

I hereby authorize you to release the following medical records including the diagnosis and records for any treatment or examination rendered to me by the above referenced physician 나는 위에 있는 의료진에게 받은 치료와 검사등을 포함한 다음과 같은 기록을 공개하는 것을 허락합니다 ____________________________

(Specific records you wish to be released 공개되길 바라는 서류들)

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to ____.

(Physician or party to whom you wish records to be released to 서류를 받을 의료진)

______________________________ ______________________________

(Patient's name and date of birth 환자 이름과 생년월일) ***(Patient's Signature 사인)***

______________________________ ______________________________

(Witness 증인) ***(Patient's Address 환자 주소)***

7350 Van Dusen Road
Suite 210 or 250
Laurel, MD 20707
301-498-5500
Fax: 301-498-7346

5500 Knoll North Dr
Suite 460
Columbia, MD 21045
410-730-9363
Fax: 410-730-2084

7610 Carroll Avenue
Suite 250
Takoma Park, MD 20912
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(02-19-15 gg)