

Greater Washington
Maternal-Fetal Medicine
and Genetics



Dear Patient,

Medical records can be transferred to you or another health care provider at your request. Please read and complete the following pursuant to Maryland Senate House Bill 716, General Health Article 4-304, in effect since October 1, 1994.

A charge may be made of \$18.54 for preparation fee and \$.61 per page for copying plus the actual cost of shipping and handling. For your convenience, we accept cash or credit cards for these payments, which must be made in advance. If you have any question or concerns regarding these fees, please feel free to contact the Montgomery County Medical Society at 301-927-4300.

The charge for your records will be \$_____ for _____ pages. Please be advised that these fees are non-refundable. If you are not picking up for records, they will be mailed within 10 days from receipt of your payment.

Sincerely,
Greater Washington Maternal-Fetal Medicine and Genetics

To: Greater Washington Maternal-Fetal Medicine and Genetics

From: Patient Name _____ Date of Birth _____

Social Security Number _____ - _____ - _____

Please Release a copy of my medical records to Dr. _____
Address:

Signature of Patient

Office use only Letter mailed _____ Payment received _____ Method of payment: cash credit check Processed by _____
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