## PrimaryCare Physicians

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## AUTHORIZATION FOR RELEASE OF INFORMATION

~ ē	NAME:		
Section 1 Patient nformation	NAME:		MI MAIDEN OR OTHER NAME
Section Patient	MO DAY YR ADDRESS:CITY:		
	PRIMARY PHONE: SECONDARY PHONE:		
Reti	<ul> <li>I hereby authorize Maryland Primary Care Physicians, LLC</li> <li>to OBTAIN my Protected Health Information, as indicated in Section 3, FROM:</li> </ul>	Section 3 Information to be Released	INFORMATION     DATES       Inistory and physical exam     Inistory and physical exam
	to RELEASE my Protected Health Information, as indicated in Section 3, in the selected format, TO:		Lab reports     Progress notes     X-ray reports     Other:
			I specifically authorize the release of information relating to:
	CITY, ST, ZIP: PHONE: FACSIMILE:		<ul> <li>Substance abuse (including alcohol/drug abuse)</li> <li>Mental health (excluding psychotherapy notes)</li> <li>HIV related information (including AIDS related testing)</li> </ul>
	EMAIL (for encryption code):		X
Section 4 Purpose Of Disclosure	<ul> <li>Changing physicians</li> <li>Continuing care</li> <li>Personal Use</li> <li>Insurance</li> <li>Other:</li> </ul>	Section 5 Type of Access	<ul> <li>Copy of record to be released to the person listed in Section 2.</li> <li>Inspection of record performed by the person listed in Section 2.</li> </ul>
Section 6 Patient Notification Elements	<ol> <li>I understand that this authorization will expire 365 days from the date I have signed this form.</li> <li>I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.</li> <li>I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.</li> <li>I understand that if I am being requested to release this information by Maryland Primary Care Physicians, LLC for the purpose of:         <ul> <li>a. My health care and payment for my health care will not be affected if I do not sign this form.</li> </ul> </li> </ol>		
Pat	<ul> <li>b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.</li> <li>5. I understand that in compliance with Maryland statute, I will pay a fee per MPCP/PMG's Access of Health Information Fee Schedule (available upon request) for copying and inspection of records.</li> </ul>		
Section 7 Authorized Signature		Section 8 FOR OFFICE USE ONLY	AUTHORIZATION EXP: (THIS DATE MUST NOT EXCEED 365 DAYS FROM THE DATE THE REQUEST WAS SIGNED.) RECORDS RECEIVED BY:
	AUTHORIZED SIGNATURE		RELATIONSHIP TO PATIENT: TYPE OF PHOTO ID PRESENTED:
	DATE  Self Durable Power of Attorney* Darent Durable Medical Power of Attorney* Legal Guardian* Health Care Agent* Other (Specify)*: *A COPY OF THE LEGAL DOCUMENTATION VERIFYING AUTHORIZATION MUST BE ATTACHED.		<ul> <li>FEE COLLECTED: \$</li></ul>
	AUTHORIZED SIGNATURE VERIFIED BY:		MPCP/PMG STAFF SIGNATURE: