Maryland Primary Care Physicians
11055 Little Patuxent Parkway, Suite 205
Columbia, MD 21044
(410) 740-0789 (410) 740-7024 Fax

AUTHORIZATION FOR RELEASE OF INFORMATION

Section 1 Patient Information

NAME: _____ _____ _____ _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ SS#: _____-_____-_____ MEDICAL RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

Section 2 Retrieval/Release Information

I hereby authorize Maryland Primary Care Physicians, LLC

- ❑ to **OBTAIN** my Protected Health Information, as indicated in Section 3, **FROM**:
- ❑ to **RELEASE** my Protected Health Information, as indicated in Section 3, in the selected format, **TO**:
  - ❑ PAPER ❑ ELECTRONIC *(on Windows compatible secured media)*

NAME: _____

ADDRESS: _____

CITY, ST, ZIP: _____

PHONE: _____

FACSIMILE: _____

EMAIL *(for encryption code)*: _____

Section 3 Information to be Released

INFORMATION	***DATES***
❑ History and physical exam ...	_____
❑ Lab reports	_____
❑ Progress notes	_____
❑ X-ray reports	_____
❑ Other: _____	

I specifically authorize the release of information relating to:

- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health (excluding psychotherapy notes)
- ❑ HIV related information (including AIDS related testing)

X _____ _____
SIGNATURE OF PATIENT OR AUTHORIZED PERSON *DATE*

Section 4 Purpose Of Disclosure

- ❑ Changing physicians
- ❑ Continuing care
- ❑ Personal Use
- ❑ Insurance
- ❑ School
- ❑ Legal
- ❑ Consultation/Second Opinion
- ❑ Workers Compensation / PIP
- ❑ Other: _____

Section 5 Type of Access

- ❑ Copy of record to be released to the person listed in Section 2.
- ❑ Inspection of record performed by the person listed in Section 2.

Section 6 Patient Notification Elements

1. I understand that this authorization will expire 365 days from the date I have signed this form.
2. 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.
3. 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.
4. I understand that if I am being requested to release this information by Maryland Primary Care Physicians, LLC for the purpose of: _____.
   a. My health care and payment for my health care will not be affected if I do not sign this form.
   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.
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.

Section 7 Authorized Signature

X _____
AUTHORIZED SIGNATURE

_____
DATE

- ❑ Self
- ❑ Parent
- ❑ Legal Guardian*
- ❑ Durable Power of Attorney*
- ❑ Durable Medical Power of Attorney*
- ❑ Health Care Agent*
- ❑ Other (Specify)*: _____

A COPY OF THE LEGAL DOCUMENTATION VERIFYING AUTHORIZATION MUST BE ATTACHED.

AUTHORIZED SIGNATURE VERIFIED BY: _____
MPCP/PMG STAFF INITIALS

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: _____

RELATIONSHIP TO PATIENT:

TYPE OF PHOTO ID PRESENTED: _____

FEE COLLECTED: $_____

- ❑ Your request to access your medical records has been denied or the release of your record in its entirety cannot be granted. Please see the attached letter for further explanation.
- ❑ This is to notify you that your original records request cannot be complied with within thirty (30) days of your original request. Your records will be released or available for inspection by _____
  NOT TO EXCEED AN ADDITIONAL THIRTY (30) DAYS.)

MPCP/PMG STAFF SIGNATURE: _____

DATE: _____