

## **Maryland Primary Care Physicians**

24A Magothy Beach Road Pasadena, MD 21122 (410) 255-2700 (410) 437-1962

## AUTHORIZATION FOR RELEASE OF INFORMATION

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۲ - ۲	NAME: LAST FIRST MI MAIDEN OR OTHER NAME		
Section 1 Patient Information	DATE OF BIRTH: SS#:		MI MAIDEN OR OTHER NAME  MEDICAL RECORD #:
Sect Par nfor	ADDRESS:CITY:		STATE:ZIP:
	PRIMARY PHONE: SECONDARY PHONE:		
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Section 2 Retrieval/Release Information	CITY, ST, ZIP:PHONE:FACSIMILE:	Section 3 Information to be Released	INFORMATION   DATES     History and physical exam     Lab reports
	EMAIL (for encryption code):		X
		] <b>،</b> ا	SIGNATURE OF PATIENT OF PRITICIPALITY IS 10014
Section 4 Purpose Of Disclosure	□ Changing physicians □ Continuing care □ Personal Use □ Insurance □ Other: □ Other:	Ac n	<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> <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> </ul> </li> <li>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> </ol>		
Section 7 Authorized Signature	AUTHORIZED SIGNATURE  DATE  DATE  DIVIDENT 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  MPCP/PMG STAFF SIGNATURE:  DATE: