Maryland PrimaryCare Physicians

Patient MRN:____________
Last Name:______________

Request for Confidential Handling of Health Information

Patient Name: ___________________________________ Date of Birth: ___________________

FAMILY & FRIENDS: It is the policy of MPCP not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information, as requested, regarding your care and treatment. **Updates to this form must be made in person.**

Name: ________________________
Relationship:___________________
Phone Number:_________________
Start Date:_____________________
End Date:______________________

☐ Diagnostic Testing Results/Appointments
☐ Rx/Medication Availability
☐ Specialist referral Availability
☐ Completed Form Availability
☐ Other:_________________________________

Name: ________________________
Relationship:___________________
Phone Number:_________________
Start Date:_____________________
End Date:______________________

☐ Diagnostic Testing Results/Appointments
☐ Rx/Medication Availability
☐ Specialist referral Availability
☐ Completed Form Availability
☐ Other:_________________________________

Name: ________________________
Relationship:___________________
Phone Number:_________________
Start Date:_____________________
End Date:______________________

☐ Diagnostic Testing Results/Appointments
☐ Rx/Medication Availability
☐ Specialist referral Availability
☐ Completed Form Availability
☐ Other:_________________________________

To **revoke** access to my Confidential Information: Please place an end date on the above listed person.

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Patient MRN:_____
Last Name:_____

Method to Receive CONFIDENTIAL Communications:

I wish to be contacted in the following manner (check all that apply):

Home: _____
☐Okay to leave message with details
☐Leave a call back number only

Cell:_____
☐Okay to leave message with details
☐Leave a call back number only

Work Telephone: _____
☐Okay to leave message with details
☐Leave a call back number only

Written Communication
☐Okay to mail to home address on file

Appointment Reminders:

☐Phone: _____

☐Cell Phone: _____

☐Email: _____

☐Work Phone: _____

Patient or Representative Signature	**Relationship to Patient**	**Date**
Employee Signature	**Location**	**Date**