Maryland Primary Care Physicians

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Authorization for Release of Health Information

Patient's Last Name | First Name | Middle Initial/Name | Maiden or Other Name (if any)

Address | Medical Record #

City | State | Zip Code

Date of Birth | Last 4 digits of Social Security # | Telephone #

I authorize Maryland Primary Care Physicians, LLC to release my protected health information as described below to:

Release Information From:	**Release Information To:**
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____ Fax:_____	Phone:_____ Fax:_____
Email:_____	Email:_____

For complete medical record and/or billing records, check below:

☐ Complete copy of medical record	☐ Itemized Billing Records

For specific information, but not the complete medical record, check below:

		Purpose of disclosure:
☐ Laboratory Reports ☐ Radiology Reports ☐ Progress Notes ☐ Immunization Records ☐ Other: _____	**I specifically authorize the release of information related to:** ☐ Drug and alcohol treatment information ☐ Behavioral or mental health records ☐ Genetic test results ☐ HIV/AIDS	☐ Personal Use ☐ Continuity of Care ☐ Legal ☐ Insurance ☐ Other:_____

For the date(s) of service from: _____ to: _____

Format of Information to be Disclosed: ☐Fax ☐Paper ☐MyChart ☐USB/Thumbdrive ☐Email ☐Mail

I have the right to revoke this authorization at any time by submitting a written request to the Health Information Management Department, except to the extent that action has already been taken in reliance on this authorization. I understand that once my health information is disclosed to the recipient named in this form, it may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws. I understand that my treatment, payment, will not be affected upon my decision to sign or refuse this authorization. I understand that a **reasonable fee may be charged** to cover the costs associated with processing and releasing the requested records in accordance with applicable laws and regulations. Unless a sooner date, event, or condition is specified, this authorization will **expire one (1) year from the date of signature** below. _____

I have read the above and fully understand the terms and conditions of this authorization.

Signature:_____ Date:_____

Print Name: _____ Phone # (if not Patient):_____

If not signed by patient; please note authority to act for patient and attach proof:

☐ Parent ☐Legal Guardian	☐ Power of Attorney ☐ Health Care Agent	☐ Other (Specify):_____