Maryland Primary Care Physicians

Patient MRN: _____
Last Name: _____

Authorization to Disclose Protected Health Information to Family and Friends

Patient Full Name: _____ Date of Birth: _____

This authorization is made in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR §164.508, and relevant Maryland law. It allows Maryland Primary Care Physicians to verbally share specific protected health information (PHI) with the individuals you designate such as family members, friends, or other personal representatives to support your healthcare, care coordination, or payment of services. Any updates to this form **must** be completed in person.

Important: This authorization does **not** permit release of your full medical record. To release your complete records, a separate Authorization for Release of Health Information must be completed.

Person Authorized to Receive Information (List one individual per form)		
Name (First, Middle, Last) _____	Phone: _____	Birth Date (mm-dd-yyyy) _____
Relationship to Patient: ☐Parent ☐Spouse ☐Child ☐Sibling ☐Other: _____		
The individual named above is authorized to obtain information in the following manners(s) (check all that apply): ☐ Scheduling/Appointment Information ☐ Billing and Payment Information ☐ Prescription and Medication Information ☐ Lab/Test Results		
Certain types of sensitive information require special authorization under Maryland and federal law. **You must check next to any category you specifically wish to include in the disclosure.** ☐Mental Health ☐Alcohol or Drug Abuse treatment ☐HIV/AIDS		
May leave voice message(s) ☐Yes ☐No		

I understand that:

- I have the right to revoke this authorization at any time in writing by submitting a revocation to Maryland Primary Care Physicians at: [7580 Buckingham Blvd, Suite 220, Hanover, MD 21076 / him@mpcp.com]
- I understand that revocation will not affect any disclosures already made based on this authorization prior to the receipt of my written revocation.
- This authorization is **valid until** _____ or until the event I specify: _____. If no date or event is listed, this authorization will **automatically expire one year from the date of signature**.
- Signing this authorization is voluntary and will not affect my access to care, treatment, payment, or eligibility for benefits.
- Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected under HIPAA, although certain categories (e.g., 42 CFR Part 2 records) may remain specially protected.
- I may request a copy of this authorization once signed.

_____ _____ _____

Signature of Patient/Authorized Individual Relationship to Patient Date

If signed by a personal representative, please print the name and indicate the relationship to the patient. If applicable, attach any legal documentation verifying authority to act on the patient's behalf (e.g., Legal Guardian, Power of Attorney).