Request for Information
From Mid-Atlantic Family Practice

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I. I hereby authorize:

Mid-Atlantic Family Practice
20251 John J. Williams Hwy.
Lewes, DE 19958
Provider: _____

TO: Name: _____
Address: _____
City_____ State _____ Zip _____
Tele #: _____ Fax #: _____

To Release the Following Information:

Patient Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

SS #: _____
DOB: _____

☐ Patient transferring out of MAFP
☐ Patient NOT transferring out of MAFP

II. Information Requested:

Date of Treatment: FROM _____ TO _____

Category of Protected Health Information (please check):

☐ Progress Notes ☐ Insurance/Correspondence ☐ Medical Imaging Reports/EKG ☐ Immunizations
☐ Medical History ☐ Laboratory Results ☐ Consults/Hospital Reports ☐ Demographic
☐ All Records

You must specifically request disclosure of the following categories:

☐ **HIV Test Results** ☐ **Drug/Alcohol Test Results** ☐ **Mental Health Records**

III. Authorization

☐ I would like this authorization to expire on/or after the date/event listed: _____

☐ I understand this authorization is only valid for ***60 days*** from the date of signature if I do not specify a date. I understand that I may revoke this consent at any time, in writing, but not retroactive to the release of information made in good faith. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy policy. I understand that treatment, payment, or other benefits cannot be conditioned on the execution of this Authorization.

Signature: _____ **Date**: _____

Printed Name: _____

If not signed by the patient, please indicate relationship:

☐ Parent, guardian or caregiver of a minor patient.

☐ Guardian or conservator of an incompetent patient.

☐ Beneficiary or personal representative of a deceased patient.

☐ Other _____ (Specify Relationship)

Accepted & Reviewed by _____