Request for Information
To Mid-Atlantic Family Practice

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

WE ACCEPT PRINTED COPIES OF MEDICAL RECORDS OR A DISC OF COPIED MEDICAL FILES

WE ACCEPT COPIES OF MEDICAL RECORDS BY FAX ONLY IF UNDER 10 PAGES

I. I hereby authorize (name of physician/provider):

Provider/Practice Name: _____

Practice Address: _____

City _____ State _____ Zip _____

Tele #: _____ Fax #: _____

To:

Mid-Atlantic Family Practice

20251 John J. Williams Hwy.

Lewes, DE 19958

Attn: _____

(Provider's Name)

To Release the Following Information:

Patient Name: _____ **DOB:** _____

Address: _____ **SS #:** _____

City: _____ **State:** _____ **Zip:** _____

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)

Revised 8/12/13