Maryland Primary Care Physicians

Maryland Primary Care Physicians
11055 Little Patuxent Pkwy., Ste 210
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AUTHORIZATION FOR RELEASE OF INFORMATION

Section 1 Patient Information

NAME: ______________________ (LAST) ______________________ (FIRST) ____ (MI) ______________________ (MAIDEN OR OTHER NAME)

DATE OF BIRTH: ____ (MO) - ____ (DAY) - ____ (YR) SS#: ____-____-____ MEDICAL RECORD #: ______________

ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP: ______

PRIMARY PHONE: ______________________ SECONDARY PHONE: ______________________

Section 2 Retrieval/Release Information

I hereby authorize Maryland Primary Care Physicians, LLC

- ❑ to **OBTAIN** my Protected Health Information, as indicated in Section 3, **FROM**:
- ❑ to **RELEASE** my Protected Health Information, as indicated in Section 3, **TO**:

NAME: ______________________

____

ADDRESS: ______________________

CITY, ST, ZIP: ______________________

PHONE: ______________________

FACSIMILE: ______________________

Section 3 Information to be Released

INFORMATION	***DATES***
❑ History and physical exam...	______
❑ Lab reports	______
❑ Progress notes....................	______
❑ X-ray reports.......................	______
❑ Other: ______	______

I specifically authorize the release of information relating to:

- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health (excluding psychotherapy notes)
- ❑ HIV related information (including AIDS related testing)

X ______________________ ______
SIGNATURE OF PATIENT OR AUTHORIZED PERSON *DATE*

Section 4 Purpose Of Disclosure

- ❑ Changing physicians
- ❑ Continuing care
- ❑ Personal Use
- ❑ Insurance
- ❑ Other: ______________________
- ❑ School
- ❑ Legal
- ❑ Consultation/Second Opinion
- ❑ Workers Compensation / PIP

Section 5 Type of Access

- ❑ Copy of record to be released to the person listed in Section 2.
- ❑ Inspection of record performed by the person listed in Section 2.

Section 6 Patient Notification Elements

1. I understand that this authorization will expire 365 days from the date I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by Maryland Primary Care Physicians, LLC for the purpose of: ______________________________________.
   a. My health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
5. I understand that in compliance with Maryland statute, I will pay a fee per MPCP/PMG's Access of Health Information Fee Schedule (available upon request) for copying and inspection of records.

Section 7 Authorized Signature

X ______________________
AUTHORIZED SIGNATURE

____
DATE

- ❑ Self
- ❑ Parent
- ❑ Legal Guardian*
- ❑ Other (Specify)*: ______________________
- ❑ Durable Power of Attorney*
- ❑ Durable Medical Power of Attorney*
- ❑ Health Care Agent*

***A COPY OF THE LEGAL DOCUMENTATION VERIFYING AUTHORIZATION MUST BE ATTACHED.**

AUTHORIZED SIGNATURE VERIFIED BY: ______________
MPCP/PMG STAFF INITIALS

Section 8 FOR OFFICE USE ONLY

AUTHORIZATION EXP: ______________
(THIS DATE MUST NOT EXCEED **365** DAYS FROM THE DATE THE REQUEST WAS SIGNED.)

RECORDS RECEIVED BY: ______________

RELATIONSHIP TO PATIENT:

TYPE OF PHOTO ID PRESENTED: ______________

FEE COLLECTED: $______________

- ❑ Your request to access your medical records has been denied or the release of your record in its entirety cannot be granted. Please see the attached letter for further explanation.
- ❑ This is to notify you that your original records request cannot be complied with within thirty (30) days of your original request. Your records will be released or available for inspection by ______________
  NOT TO EXCEED AN ADDITIONAL THIRTY (30) DAYS.)

MPCP/PMG STAFF SIGNATURE: ______________

DATE: ______________