ATTENTION: MEDICAL RECORDS
1300 York Road, Suite 30D
Lutherville, MD 21093
Phone: 855-871-3347
Fax: 443-557-6699

Authorization for Use and Disclosure of Protected Health Information

Name of Patient (First, Middle, Last) ________________ Maiden or Previous Name ____________ Date of Birth ________

Address ____________________ Apt ____ City ______________ State ___ Zip __________

Phone (Home) ______________ Phone (Work) ____________________ Phone (Cell) ____________

AUTHORIZE:	**RELEASE RECORDS TO:**
Name of Physician / Healthcare Facility ________________	Name of Physician / Healthcare Facility ________________
Street Address ________________________	Street Address ________________________
City ____________ State _______ Zip _______	City ____________ State _______ Zip _______
Phone ______________ Fax ____________	Phone ______________ Fax ____________

Information to be Released

Date Range: From__________ To______________

❑ Progress Notes ❑ Consultation(s) ❑ Laboratory Results ❑ Immunotherapy Records/Formulation ❑ X-ray/Radiology Reports

❑ Other: ____

Reason for Disclosure

I would like this information released for the following purpose (s):

❑ Continued care by another provider ❑ Attorney ❑ Insurance Purposes ❑ Social Security/Disability ❑ Personal Use

❑ Other: ____

If leaving our clinic (s) - Reason

❑ Dissatisfaction ❑ Moving ❑ Insurance ❑ Convenience of Hours/Location

❑ Other ____

I have read and understand the following:

** This authorization expires one year after I sign it or someone else (specify here ____________). This time period noted here may exceed one year only in certain situations specified by law.*

** I may revoke this authorization at any time by notifying the facility in writing that I have authorized to release my records and this authorization will cease to be effective on the date notified. This will not apply to records that have already been released.*

** The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations. However, other state and federal law may prohibit the recipient from disclosing specially protected information. Once the records are released, we can nor prevent them from being released to a third party.*

** There may be a fee for releasing these records.*

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Name of Patient or Authorized Party** (Print) Signature of Patient or Authorized Party Date

***Parent, Guardian, Power of Attorney, etc.*