

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION



Patient Name _____ Date of Birth: _____

I, the undersigned, authorize _____
NAME AND ADDRESS OF FORMER PRIMARY CARE PROVIDER

to release or give access to the protected health information of the above named patient to:
*Middletown Valley Family Medicine, P.A.
300 South Church Street, P.O. Box 20
Middletown, Maryland 21769
Phone: 301-371-9000 Fax: 240-566-7000*

METHOD OF DELIVERY

Mail Fax Pick-up

1) EFFECTIVE TIME PERIOD

This authorization is valid until the earlier of the patients death, the patient reaching the age of majority, or permission is withdrawn from the following specific date or event occurs (optional) _____.

2) PATIENT INFORMATION IS NEEDED FOR: (please select at least one option)

Treatment Disability Billing/Claims Legal Other _____

3) INFORMATION TO BE RELEASED OR ACCESSED: All health records from _____ to _____
DATE DATE

Immunization Billing Diagnostic Reports Other: _____

Your initials are required to release the following information. (Initial in box)

<input type="checkbox"/> Mental Health (excluding psychotherapy notes)	<input type="checkbox"/> Genetic Information (including test results)
<input type="checkbox"/> Drug, Alcohol, or Substance Abuse Records	<input type="checkbox"/> HIV/AIDS Test result/Treatment

SIGNATURE AUTHORIZATION: By signing below, I understand the following:

- a) I may revoke this authorization any time by sending a written revocation to the person/organization listed above. I understand the revocation will not apply to any health information previously disclosed in reliance of this authorization.
- b) Any treatment, payment or my enrollment in any health plan, or my eligibility for benefits will not be affected if I do not sign this authorization.
- c) Any information disclosed by this authorization to any person/organization not a health care provider, business associate of a health care provider or health plan covered by federal and state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations.
- d) I am entitled to receive a copy of this sign authorization.

SIGNATURE X _____
SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE DATE

PRINTED NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

Specify relationship to the patient: Self Parent of minor* Guardian/Ward* Other[†]: _____

SIGNATURE X _____
SIGNATURE OF MINOR DATE

(Photo identification will be requested to verify the identity of the person signing this authorization.)