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: 301-371-8905

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is valid until the earlier of the patients death, the patient reaching the age of majority, or permission is withdrawn from the following specific date or event occurs (optional) ____________.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

☐	Mental Health (excluding psychotherapy notes)	☐	Genetic Information (including test results)
☐	Drug, Alcohol, or Substance Abuse Records	☐	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 REPRESENATIVE DATE

____
PRINTED NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENATIVE

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.

Note: There will be a flat fee of $20.00 plus postage (if applicable) for processing the release of each patient's medical record. Fee must be paid in full before the record will be copied.