

**AUTHORIZATION FOR RELEASE
OF MEDICAL RECORDS**

Park Medical Associates
Lutherville, MD

10755 Falls Rd. Ste. 200
Fax: 410.583.7128

For this authorization, "My Health Information" is:

____ Complete Record

Other: _____

For the date(s) of service starting *[Insert date(s) of service requested]*: _____

I authorize *[Entity]* _____

to disclose My Health Information to *[Name of person or entity]* _____

for *[Purpose]* _____.

My Health Information should be sent to:

[Contact name at entity, if applicable] _____

[Street Address] _____

[City, State and Zip Code] _____

Phone _____ Fax _____

I understand there is a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland State guidelines. By signing this authorization, I agree to pay these fees in order for this request to be processed.

The medical and administrative staff of Park Medical Associates pledge to maintain strict patient confidentiality in keeping with high ethical standards and in accordance with state and federal law. Park Medical Associates has procedures in place to support this policy. These procedures make it very unlikely that my health information will be improperly redisclosed.

Patient Name: _____ (first) _____ (initial) _____ (last)

Signature: _____ **Date:** _____

Address: _____ (street address)

_____ (city) _____ (state) _____ (zip code)

Phone: _____ (area code) _____ (home phone number)

Medical Record #: _____

SSN: _____ **Birth Date:** _____

For healthcare agent/guardian/surrogate/parent/Personal Representative of the deceased,

(circle one of the above)

I, _____, represent that I am the representative for the patient as circled above.

(insert your name)

Representative's Signature: _____

Address: _____ **Phone:** _____

If you are the healthcare agent or guardian or court appointed Personal Representative of the deceased, please attach proof of your authority to act on behalf of the patient.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

Notice to the recipient of these records: If the information concerns a person treated for alcohol or drug abuse, the confidentiality of this information is protected by federal law (Federal Regulation 42 CFR part 2) and prohibits further disclosure of this information except with specific written authorization of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose.