AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (Updated 3/17/17)

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Fax: 410.583.7155

*** ***THERE IS A CHARGE FOR COPYING AND HANDLING MEDICAL RECORDS REQUESTS.*** ***

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.

For this authorization, "My Health Information" is: ____Complete Record, ***OR***

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 ______________________

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. This Authorization will expire one year from date signed. You have the right to revoke this Authorization as long as the request has not been fulfilled. To revoke this authorization you must submit your request in writing to the address above.

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

Signature: ______________________ Date: ______________________

Address: ______________________
(street address)

____
(city) (state) (zip code)

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

Medical Record # ______________________

SSN: ______________________ Date of Birth: ______________________

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.**

Original: Medical Records Copy: Patient