Mid-Atlantic Family Practice

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I.

Patient's Name: _____ Patient's DOB: _____

☐ PATIENT TRANSFERRING OUT OF MAFP

I hereby authorize:

Release of Records **TO / FROM** (PLEASE CIRCLE ONE) **:**	Release of Records **TO / FROM** (PLEASE CIRCLE ONE) **:**
Company/Name:	Company/Name:
Address:	Address:
City:	City:
State: Zip Code:	State: Zip Code:
Phone:	Phone:
Fax:	Fax:

II.

☐ **ALL RECORDS -Medical records may contain information pertaining to psychiatric, drug and /or alcohol, mental health diagnosis and treatment. Please initial this box if you wish not to disclose this information _____.**

Or

To release the following information to above mentioned:

Date of Treatment: From: _____ to _____

Category of Protected Health Information:

☐ Progress Notes ☐ Insurance /Correspondence ☐ Medical Imaging Reports/EKG ☐ Immunizations ☐ Demographics

☐ Medical History ☐ Laboratory Results ☐ Consultation/ Hospital Reports ☐ other: _____

III.

Authorization

☐ I would like this authorization to expire on/or after the date/event listed: _____

OR

☐ I understand this authorization is only valid for ***60 days*** from the date of signature if I do not specify a date. I understand I may revoke this consent at any time, in writing, but not retroactive to the release of information made in good faith.

(initial)_____ I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions written above. The information that is to be used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of Patient: _____

Print Name: _____

Signature of Personal Representative: _____

Relationship:_____

Print Name: _____Date of Signature: _____

DO NOT WRITE BELOW LINE: OFFICE USE ONLY

Accepted and Reviewed By: _____

Date: _____