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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:______________________________ Date of Birth:________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name:____

Address:____

City:__________________________ State:____________ Zip Code:___________

This request and authorization applies to (Please check one below):

☐ Healthcare information relating to the following treatment, condition or

dates:____

☐ All healthcare information

☐ Other:____

PURPOSE OR NEED FOR THIS INFORMATION:

____

____

Patient Signature:____ Date:__________

There will be a fee assessed for copying records as provided by Maryland law:

A fee for copying, not to exceed 76 cents for each page of the medical record and the actual cost of postage and handling. An additional preparation fee of $22.28 will be charged if the records are sent to another provider. The Federal HIPAA regulations do not allow a charge for a preparation fee for records provided directly to the patient.

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED