Authorization for Release of Medical Records

Owensville Primary Care
134 Owensville Road
West River, Md. 20778
(T) 410-867-4700 (F) 855-772-1468

I authorize the following protected health information to be release from the medical record of:

Last Name	First Name	Today's Date
Birthdate	Email Address	Phone Number

Release Records To From

Owensville Primary Care
134 Owensville Road
West River, Md. 20778
(T) 410-867-4700
(F) 410-867-4934

Release Records To From

Name/Organization

Address

City / State / Zip

Phone Fax

Please mail my records **Please call when my records are ready for pick up** **Please fax my records**

I understand that to the extent that any recipient of this information, as identified above, is not a "covered entity" under Federal or Maryland privacy law, the information may no longer be protected by by Federal and Maryland privacy laws once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

TO BE RELEASED	Date of Service / Provider	TO BE RELEASED	Date of Service / Provider
Chart Summary		Immunizations	
Office visit & lab		Physical Therapy notes	
GYN visit & lab		Radiology reports	
Urgent Care visits		Entire Record	
Lab work		Other	

➔ Note: If specific dates to be released or a specific provider are not indicated, all records in the category marked will be released.

REASON RELEASE OF INFORMATION

At the request of the individual

Other (Describe reason for Disclosure) _____

Indicate the PURPOSE for this disclosure:_____

I understand that the information in my health record may include information relation to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I have the right to revoke this authorization I must do so in writing and in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____.

If I fail to specify and expiration date, event or condition, this authorization will expire in six months of dated signature. I understand that authorizing the disclosure of this phi is voluntary. I need not sign this for in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact OPC Privacy Officer.

I understand that I may incur a charge for the coping or inspection of patient records. A minimum clerical fee of $_____and per page fee of $_____ .

Signature of Patient or Patient Representative	Printed Name/Relationship of Patient Representative	Date

If documents are being picked up at OPC, from someone other than the patient. This authorization form must indicate this accordingly

Signature of person picking up documents	Printed Name/Relationship	Date