AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

This Authorization form meets or exceeds all requirements of Federal Privacy Regulations issued by the Department of Health and Human Services at 42 CFR § 164.508 and the Annotated Code of Maryland, Title 10 Health General Articles §§ 4-301– 4-307.

I hereby authorize_____ to release the protected health information of:

PATIENT:_____

DATE OF BIRTH: _____ PHONE: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

The information is to be released to:

Keatts and Horton, LLC
7 Central Avenue, Suite 203
Glen Burnie, Maryland 21061
(410) 863-1020

The information I wish to have released includes but is not limited to:

_____

- ☐ Discharge summary
- ☐ History and physical exam
- ☐ Consultation reports
- ☐ Reports of operations
- ☐ Nursing Notes
- ☐ Progress Notes
- ☐ Itemized Statements and/or Medical Bills
- ☐ Imaging reports
- ☐ Diagnostic cardiology reports
- ☐ Laboratory reports
- ☐ Other _____
- ☐ Doctor's orders _____

I do___ I do not ___ wish to have information about HIV/AIDS released under this authorization.
I do___ I do not ___ wish to have mental health records released under this authorization.
I do___ I do not ___ wish to have information about drug/alcohol abuse treatment released under this authorization.

If in possession of records from another provider, I do____ I do not ___ wish to have those records released under this authorization.

The purpose for such disclosure is:

- ☐ At my request (only patient may check)
- ☐ Payment / Insurance

□ Healthcare □ Employment
□ Other_____
This authorization will expire one year from the date it is signed unless a shorter time is indicated here:

I understand: (Initial)

_____ This authorization is voluntary.

_____ My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.

_____ I may receive a copy of this form.

_____ I may inspect my protected health information without signing this form.

_____ This authorization to disclose information may be revoked by me at any time, expect to the extent that action has been taken prior to receipt of revocation. To revoke the authorization, I understand that I must notify the health care provider referenced above in writing.

_____ I understand that once information covered by this authorization has been disclosed, re-disclosure of the information by that recipient is possible and the information may no longer be protected by the federal regulation referenced above but may be protected by Maryland law.

_____ _____
Patient or Personal Representative's Signature Date

If signature is other than patient, explanation of authority to act for the patient:_____

_____.

_____ _____
Witness Date