P.O. Box 1978 Salisbury, MD 21802
Medical Records Fax Nos:
Princess Anne 410-651-1011
Salisbury 410-219-1072 Pocomoke 410-957-0152
Phillip Morris Drive OB/Gyn 410-742-6633
Riverside Drive - 410-548-5773
Woodbrooke – 410-546-2656

" PLEASE PRINT "

Authorization for Release of Medical Records

Patient's name_____ DOB_____ SS# _____

Address_____ Phone _____

1. Persons or group of persons authorized to **use/disclose** this information and purpose:

☐ Chesapeake Health Care
☐ _____
Name of physician/provider
_____
Street State Zip

Purpose: ☐ My personal health records
☐ Transferring to another provider
☐ Sharing information with another provider
☐ Other _____
_____

2. Persons or group of persons authorized to **receive** this information:

☐ Chesapeake Health Care ☐ Me

☐ _____
Name
_____ _____ _____
Street State Zip Telephone Fax

3. Description of information to be used or disclosed: *(Please mark box with an X)*

☐ Copies by mail ☐ Records of health care ☐ Mental Health records ☐ Shot records
☐ Dental records ☐X-ray & other images ☐ HIV information

4. ***This section must be completed if request for disclosure is made by someone other than the above-named patient:***

Purpose for disclosure:

I understand that the person I am authorizing to use/disclose my protected health information may receive compensation for doing so. _____ (patient initials)

I understand that I may refuse to sign this authorization and that if I do, it will not affect my ability to obtain treatment or payment or eligibility for benefits and that I may inspect or copy any information used or disclosed under this authorization. _____ (patient initials)

5. I understand that if the party receiving this information is not a health care provider or health plan subject to the federal privacy regulations that the information described above may be redisclosed and no longer protected by the privacy regulations. _____ (patient's initials)

6. I understand that I may revoke this authorization in writing at any time except to the extent that action on this authorization has not already occurred and that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 and 164._____(patient's initials)

7. This authorization becomes effective _____ and will expire on _____.
Date *Date*

_____ _____ _____
Patient (or Representative) Signature *Relationship to Patient* *Date*

_____ _____
Witness Signature *Date*