



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:**

<input type="checkbox"/> Chesapeake Health Care	Purpose:	<input type="checkbox"/> My personal health records
<input type="checkbox"/> _____ Name of physician/provider		<input type="checkbox"/> Transferring to another provider
_____		<input type="checkbox"/> Sharing information with another provider
Street _____ State _____ Zip _____		<input type="checkbox"/> Other _____

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

<input type="checkbox"/> Chesapeake Health Care	<input type="checkbox"/> Me
<input type="checkbox"/> _____ Name	
Street _____ State _____ Zip _____	Telephone _____ Fax _____

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

<input type="checkbox"/> Copies by mail	<input type="checkbox"/> Records of health care	<input type="checkbox"/> Mental Health records	<input type="checkbox"/> Shot records
<input type="checkbox"/> Dental records	<input type="checkbox"/> X-ray & other images	<input type="checkbox"/> 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 \_\_\_\_\_ Date \_\_\_\_\_ and will expire on \_\_\_\_\_ Date \_\_\_\_\_.

\_\_\_\_\_  
*Patient (or Representative) Signature*                      *Relationship to Patient*                      *Date*

\_\_\_\_\_  
*Witness Signature*                      *Date*