Chesapeake
HEALTH CARE

P.O. Box 1978 Salisbury, MD 21802
Medical Records Fax Nos:
Berlin 410-973-2843
PMD Peds 410-219-5976
Pocomoke 410-957-0152
Princess Anne 410-651-1077
Riverside MH 443-358-6194
Sweetbay MH 410-219-3446
Woodbrooke Adult Med. 410-546-2656
Woodbrooke GYN 410-742-6633

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

☐ _____
Name of physician/provider
_____
Street State Zip

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

☐ Chesapeake Health Care Phone _____ Fax _____ ☐ Me

☐ _____
Name
_____ _____ _____
Street State Zip Telephone Fax

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

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

4. 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 *Patient (or Representative) Printed Name* *Relationship to Patient* *Date*

_____ _____ _____
Witness Signature *Witness Printed Name* *Date*