P.O. Box 1978 Salisbury, MD 21802

Medical Records Fax Nos:

Berlin 855-313-8264
Healthway MH 866-524-1484
PMD Peds 844-297-7497
Pocomoke 866-656-9132
Power St. Family Med. 833-464-4452
Princess Anne Adult Med. 866-656-8946
Princess Anne MH 866-656-9117
Princess Anne OB/GYN 866-656-9118
Princess Anne Peds 866-656-9119
Riverside MH 844-536-8418
Sweetbay Adult Med. 833-305-0459
Woodbrooke Adult Med. 866-668-1786
Woodbrooke OB/GYN 866-656-9131

" 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

Phone_____

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

Fax_____

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

☐ Chesapeake Health Care ☐ Myself/Representative ☐ Address Above ☐ Other _____
☐ _____
Name
_____ _____ _____
Street State Zip Telephone Fax

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

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

4. **Select delivery method:** *(Please mark box with an X)*

☐ Patient portal ☐ Encrypted email _____
(Email Address)
☐ Fax _____ ☐ U.S. mail ☐ Certified Overnight Delivery (extra charge)
(Fax Number)

5. I understand that the person I am authorizing to use/disclose my protected health information may receive compensation for doing so. 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 eligibility for benefits and that I may inspect or copy any information used or disclosed under this authorization. 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. 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)

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

Per Maryland State guidelines, Chesapeake Health Care has 21 business days to release your medical records.

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

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