



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 Street Peds 410-630-1682
- 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
- S. Division St. 833-464-4452
- Winterplace Adult Med. 833-449-4699
- 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:**

<input type="checkbox"/> Chesapeake Health Care <input type="checkbox"/> _____ Name of physician/provider _____ Street _____ State _____ Zip _____ Phone _____ Fax _____	Purpose: <input type="checkbox"/> My personal health records <input type="checkbox"/> Transferring to another provider <input type="checkbox"/> Sharing information with another provider <input type="checkbox"/> Other _____
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**2. Persons or group of persons authorized to receive this information:**

<input type="checkbox"/> Chesapeake Health Care <input type="checkbox"/> _____ Name _____ Street _____ State _____ Zip _____	<input type="checkbox"/> Myself/Representative <input type="checkbox"/> Address Above <input type="checkbox"/> Other _____	Telephone _____ Fax _____
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**3. Description of information to be used or disclosed:** *(Please mark box with an X)* **Date Range:**

<input type="checkbox"/> Records of health care <input type="checkbox"/> Dental records	<input type="checkbox"/> Mental Health records <input type="checkbox"/> X-ray & other images	<input type="checkbox"/> HIV information <input type="checkbox"/> Lab Results	<input type="checkbox"/> Shot records <input type="checkbox"/> Other _____
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**4. Select delivery method:** *(Please mark box with an X)*

<input type="checkbox"/> Patient portal <input type="checkbox"/> Fax _____ (Fax Number)	<input type="checkbox"/> Encrypted email _____ (Email Address)	<input type="checkbox"/> U.S. mail <input type="checkbox"/> Certified Overnight Delivery (extra charge)
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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 \_\_\_\_\_ Date and will expire on \_\_\_\_\_ 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*