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Advanced Endocrinology

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name _____ Patient's Date of Birth _____

Address _____ **Patient's Telephone Number** _____

City, State Zip Code _____ **Any Other Name(s) Used** _____

I request that my provider share my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):

   _____

2. Be sent to the following person / entity at the address listed below:

   Name _____

   Address _____

   City **State** **Zip Code** **Email Address** _____

3. I hereby authorize disclosure of the following information:

   ☐ My entire medical record ☐ Immunization Records Only ☐ Service Dates Only: _____ to _____

   ☐ Specific Information Only: _____

   _____

NOTES: 1) INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH IS INCLUDED UNLESS YOU SPECIFICALLY REQUEST THAT IT BE EXCLUDED. 2) IF YOU REQUEST RECORDS BE SENT TO A TREATING PROVIDER AND YOU DO NOT WANT YOUR ENTIRE RECORD SENT, WE WILL SEND YOUR RECORDS TO YOU FOR DELIVERY TO YOUR PROVIDER; WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.

☐ **PLEASE EXCLUDE THE FOLLOWING INFORMATION:** _____

_____ **Signature:** _____

4. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. If I **do not specify a format below,** I **understand that my PHI will be mailed to at the address listed above in hard copy/paper format.** I **hereby request that my PHI be provided in the following format:** ☐ via secure electronic delivery; or ☐ other (please specify) _____
5. If I have requested records be sent unencrypted, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
6. Ifl requested records be mailed to me, I understand I will be charged for the cost of paper and postage; ifl request my records on a USB drive or similar, I will be charged the cost of that device.
7. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and would then no longer be protected by federal privacy regulations.
8. I understand I may revoke this authorization by notifying my provider OR aestaff@advancedendo.org in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
9. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify) _____
10. This authorization expires on _____ , 20__ , OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please specify) _____

FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. Please see https://health.maryland.gov/mbpme/Documents/medchi21.pdf for details.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

Signature of Patient	Date of Patient's Signature	Patient's Date of Birth
If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate	Date of Legal Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual