Name

DOB

Date

Garrett Medical Group, P.A.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:	**ID Number:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Persons/organizations providing the information:

_____

_____

_____

_____

Persons/organizations receiving the information:

_____

_____

_____

_____

Reason for leaving Garrett Medical Group: _____

_____

Please specify what records you would like to copy:

☐ All records

☐ All records between the dates of _____ and _____

☐ Records pertaining to _____

I specifically authorize the release of any and all, information relating to (check & initial if applicable)

☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)

☐ Psychiatric care ☐ Treatment for alcohol and/or drug abuse

****Please note that Maryland law stipulates the prepaid fees for medical record copying are as follows: - Preparation fee of no more than $19.09, plus a fee of no more than $.63 cents per page copied, plus the actual cost of shipping and handling**

Please specify method of release: ☐ *Pick-up* ☐ *1st Class Mail* ☐ *Certified Mail to* *(minimum $10 charge)*

We may or may not charge this full amount based upon a given situation:

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____ Initials _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any affect on any actions they took before they received the revocation.

Initials _____

_____ _____

Signature of patient or patient's representative Date

(Form MUST be completed before signing.)

Printed name of patient's representative: _____

Relationship to the patient: _____

Date Records Mailed/Picked-up: _____

Fees for Copying and Mail: _____