

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

**\*PLEASE COMPLETE ALL SECTIONS OF THIS FORM FOR THE RELEASE OF YOUR MEDICAL RECORDS\***

Name of Patient\*: \_\_\_\_\_

Social Security Number\*: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_

Date of Birth\*: \_\_\_\_\_

\_\_\_\_\_

I hereby request that:

Plotsky Medical Associates, P.C.  
15225 Shady Grove Road, Suite 102  
Rockville, MD 20850  
Phone: 301 330-0661  
Fax: 301 977-6940

Or any other such person as they may authorize, and permit them to copy, examine or reproduce in any manner, any and all portions desired by them of the following:

Include date range of information to be released \_\_\_\_\_

Description of information to be released, check all that apply

\_\_\_\_\_ Entire Medical Record

\_\_\_\_\_ History And Physical

\_\_\_\_\_ Progress Notes

\_\_\_\_\_ Consultation Notes

\_\_\_\_\_ Billing Records

\_\_\_\_\_ Radiological Reports

\_\_\_\_\_ EKG

\_\_\_\_\_ Labs

\_\_\_\_\_ All Records

\_\_\_\_\_ Other (specify) \_\_\_\_\_

The recipient of the medical record information:

\_\_\_\_\_ Myself (or parent/guardian)

\_\_\_\_\_ Other

Name\* \_\_\_\_\_

Name\* \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**This is a patient request and the patient is responsible for payment prior to the fulfillment of this request. Fee: \$0.69 per page plus postage.**

I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that I am required to sign this authorization in the event that I am requesting medical records and that this consent may be revoked in writing at any time, with the exception to the extent that disclosure has already occurred prior to the receipt of revocation by the named provider. To initiate revocation of this authorization a direct written correspondence must be sent to the healthcare provider above within 30 days from the request.

*I certify that I have read, signed and received a copy of this authorization upon my request.*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Relationship to Patient*