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 _____ **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: $0.76 per page plus postage.
Maryland Law allowing for charge: http://www.mbp.state.md.us/pages/faq_records.htm

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*