PLOTSKY MEDICAL ASSOCIATES

Authorization for the Release Protected Health Information (PHI)

PATIENT	DOB	DATE

I hereby request that:
Plotsky Medical Associates, or any such person as they may authorize, is permitted to copy, examine, or reproduce all portions of my PHI that is desired by them.

Date Range to be released: _____

Information to be released (check all that apply):
[ ] Entire medical record [ ] Office Visit Notes [ ] Lab Results

[ ] Imaging Results [ ] Billing Records [ ] Progress Notes

[ ] Other:_____
_____

Recipient of records to be released:
[ ] Myself [ ] Other:

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 and a processing fee of $22.88. Maryland law allowing for charge: www.mbp.state.md.us/pages/faq_records.

I understand that the medical provider to whom this authorization is furnished may not condition his or her treatment of me on whether I sign the authorization. I understand that I am required to sign this authorization if I am requesting medical records. This consent can be revoked at any time with a written request which must be received by the healthcare provider within 30 days of this request.
I certify that I have read and will receive a copy of this request.

PATIENT/RESPONSIBLE PARTY SIGNATURE	DATE