Anne Arundel Medical Group — Authorization for Use and Disclosure of Medical Information

Please fax completed form to 443-481-4135, bring to the office, or mail to
Anne Arundel Medical Group, Attn: HCE Healthport, 201 Defense Highway, Suite 150, Annapolis, MD 21401.

Patient Information: Print Name: _____ Date Of Birth: _____

SS# (Last 4 digits) _____ Maiden or Prior Last Name: _____ Phone: _____

Release my healthcare information from:

Name of Facility/Provider: _____ Tax ID: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Send my healthcare information to:

Name of Recipient Facility/Provider: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Format of Information To Be Released: ☐ Paper (mail or Fax) ☐ Digital (Encrypted e-mail)

Information to be released:

- ☐ Abstract of Health Information
- ☐ Two most recent years of Pertinent Information (Chart notes, labs, ultrasounds and special tests)
- ☐ Complete Medical Record
- ☐ Other (Specify): _____

Purpose of request

- ☐ Continuing Care
- ☐ Personal Use
- ☐ Workman's Compensation
- ☐ Disability Determination
- ☐ Other (Specify) _____

Dated of information to be released:

Health records from _____ to _____ only Billing records from _____ to _____

Fees for copying medical records

The following fees will apply:
The actual retrieval fee for medical records stored off site $ _____
A base preparation fee of $ _____ (waived for patient requests).
A charge of $ _____ cents per photocopied page, and the actual cost of postage $ _____
These fees must be paid before your records can be released.

My rights

I understand I have their right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing, and present to the office where my information is being released. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or receive copies of the information to be used or disclosed, as provided in the Code of Federal Regulations (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Patient authorization

I understand that I may be charged the fees shown above for the coying of my medical records. I authorize _____ to release my medical records (including medical information related to a diagnosis or treatment for HIV testing, drug and alcohol, or psychiatric condition) as specified above.

Signature: _____ Date: _____

(Patient, Guardian*, Authorized Representative*) *Must provide documentation to prove authority to sign on behalf of the patient

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED