Waugh Chapel Family Medicine
Authorization for Release of Information
2401 Brandermill Boulevard, Suite 250
Gambrills, MD 21054
Office: 410-721-1507 Fax: 410-721-1510

Patient Information:

Print name:____ Date of Birth: ____________

Address: ____

SS#: ________________________________ Maiden or prior name:_________________________

Please release my healthcare information from:

Name of Facility/Provider:

____

Address:

____

City/State/Zip

____

Phone Number:

____

Please send my healthcare information to:

Waugh Chapel Family Medicine

2401 Brandermill Blvd, Ste 250
Gambrills, MD 21054
Phone #: 410-721-1507, Fax: 410-721-1510

Information to be released (please check the appropriate box):

- ❑ The most recent 2 years of pertinent information (chart notes, labs, ultrasounds and special tests)
- ❑ All medical records
- ❑ Specific information (please specify)

Purpose for which disclosure is being made (please check appropriate box if relevant):

- ❑ Sharing with other health care providers
- ❑ Legal investigation
- ❑ Other:
- ❑ Personal use
- ❑ I am transferring my care to a new health care provider

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Patient Authorization

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). If requested in the future, Waugh Chapel Family Medicine is specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

My Rights

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. (To view the process for revoking this authorization, please read our Privacy Notice to patients on-line, or as posted at the facility where your information is being released.) I understand that once the health information I may in the future authorize to be disclosed to someone else, reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Fees for Copying Medical Records

Your prior health care provider may charge fees for photocopying your records. Please, inquire of them what their fees are for this service.

Signature: ____ Date: ________________________

(Patient, Guardian, Authorized Representative* - * Please provide documents to prove authority to sign on behalf of the patient)*

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED

Up dated: 11/26/2004