

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Name of Patient: _____ Soc. Security #: _____
Address: _____ Phone Number: _____
City, ST, ZIP _____ Date of Birth: _____ / ____ / ____
Email Address: _____

1. Type of Request: I hereby request that:

Provide the following PHI and process it thru:

MARYLAND HEART, P.C.

6410 Rockledge Drive, Suite 200
Bethesda, Maryland 20817
Phone: (301) 897-5301
Fax: (301) 301-897-9589
www.mhmnds.com



12800 Middlebrook Road, Suite 400
Germantown, MD 20874
Phone: 301-916-4700
Fax: 301-916-8776

www.universata.com

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

2. Reason for Release: Personal Copy Transfer to New Doctor Moving Attorney/Legal Insurance

3. PHI to be Released (include discharge date(s), date (s) of service, etc.) _____

4. Description of PHI to be Released: (Check ALL that apply)

<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Catheterization Report	<input type="checkbox"/> Consultation Report
<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> EKG	<input type="checkbox"/> Holter Monitor Report
<input type="checkbox"/> Labs	<input type="checkbox"/> Medication List	<input type="checkbox"/> Nuclear Stress Test
<input type="checkbox"/> Office Visit Note	<input type="checkbox"/> Problem List	<input type="checkbox"/> Stress Test
<input type="checkbox"/> X-Rays	<input type="checkbox"/> All Records: Film, Video, CD, Billing	<input type="checkbox"/> Other (Specify) _____

5. Specific Confidential PHI Authorized for This Release:

By signing my initials next to the specific category of highly confidential PHI, I am authorizing **Maryland Heart, P.C.** to release the indicated type of information next to my initials pursuant to this Authorization from the treatment date(s) listed above.

<input type="checkbox"/> HIV/AIDS Related Information	<input type="checkbox"/> Drug and Alcohol Information	<input type="checkbox"/> Genetic Information
<input type="checkbox"/> Mental Health & Psychotherapy Information	<input type="checkbox"/> Sexually Transmitted Disease Information	<input type="checkbox"/> Tuberculosis

6. Release PHI To: [For faster delivery list an Email address to which we may send a secure web link or FAX number]

<input type="checkbox"/> Myself (the patient or guardian)	<input type="checkbox"/> Organization/Insurance Provider/Attorney etc.
Name: _____	Name: _____
Address: _____	Address: _____
FAX: _____	FAX: _____
E-Mail: _____	E-Mail: _____

7. Responsible Entity To be Billed for PHI:

<input type="checkbox"/> Myself (the patient or guardian)	<input type="checkbox"/> Organization/Insurance Provider/Attorney etc.
Name: _____	Name: _____
Address: _____	Address: _____

Fees: I understand the State of Maryland and Federal Law allow for fees to be assessed for copies of my medical records and any applicable mailing/postage fees: I will be charged \$0.69 per page plus Fulfillment Fee (Actual Postage). Send these records via: Internet (link to secure website) FAX Mail

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 not required to sign this authorization and that this consent may be revoked in writing at any time. To initiate revocation of this authorization a direct written correspondence must be sent to **Maryland Heart, P.C.** within 30 days from the request. Records are normally sent out within 10 business days.

I certify that I have read, signed and received a copy of this authorization upon my request. I understand I will be billed.

Signature _____

Date _____

Relationship to patient _____

