COMPREHENSIVE PRIMARY CARE & ASSOCIATES, P.L.L.C.

AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION

PLEASE COMPLETE ALL SECTIOS OF THIS FORM FOR THE RELEASE OF YOUR MEDICAL RECORDS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE OFFICE OR ASK THE FRONT DESK STAFF.

NAME: _____

SSN: _____-_____-_____ DATE OF BIRTH: _____ /_____ /_____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

1. TYPE OF REQUEST: I HEREBY REQUEST THAT:
   COMPREHENSIVE PRIMARY CARE AND ASSOCIATES, P.L.L.C.
   ATTN: MEDEICAL RECORDS DEPT.
   15825 SHADY GROVE ROAD SUITE 140
   ROCKVILLE, MD 20850
   PHONE: (301) 869-9776 FAX: (301) 417-4947

   OR ANY SUCH PERSON AS THEY MAY AUTHORIZE, AND PERMIT THEM TO EXAMINE, COPY OR REPRODUCE IN ANY MANNER, ANY AND ALL PORTIONS DESIRED BY THEM TO THE FOLLOWING:

2. INCLUDE PHI DATE RANGE TO BE RELEASED: _____

3. DESCRIPTION OF PHI TO BE RELEASED (CHECK ALL THAT APPLY)

☐ ENTIRE MEDICAL RECORD	☐ PATHOLOGY REPORTS	☐ EKG/EEG
☐ HISTORY AND PHYSICAL	☐ BILLING RECORDS	☐ LABS
☐ PROGRESS NOTES	☐ OPERATIVE REPORTS	☐ ALL RECORDS
☐ CONSULTATION NOTES	☐ X-RAYS	☐ OTHER: _____

4. IF APPLICABLE, PLEASE CHECK SPECIFIC CONFIDENTAL PHI AUTHORIZED FOR RELEASE:

☐ HIV/AIDS RELATED INFO	☐ MENTAL HEALTH & PHSYCH INFO	☐ GENETIC INFO
☐ DRUG & ALCOHOL INFO	☐ SEXUALLY TRANSMITTED DISEASE INFO	☐ TUBERCULOSIS INFO

5. THE RECIPIENT OF THE MEDICAL RECORD INFO: (AN INVOICE/BILL WILL BE SENT FOR EACH REQUEST)

☐ MYSELF (THE PATIENT OR GAURDIAN)	☐ OTHER
NAME: _____	NAME: _____
ADDRESS: _____	ADDRESS: _____

6. RESPONSIBLE ENTITY TO BE BILLED FOR MEDICAL RECORD INFORMATION:

☐ MYSELF (THE PATIENT OR GAURDIAN)	☐ OTHER
NAME: _____	NAME: _____
ADDRESS: _____	ADDRESS: _____

THIS IS A PATIENT REQUEST: THE PATIENT WILL BE CHARGED FOR THE MEDICAL RECORD UNLESS OTHERWISE NOTED. THE FEE IS **$0.76 PER PAGE** AND FULLFILLMENT FEE (ACUTAL COST OF POSTAGE). A MEDICAL RECORD BEING SENT DIRECTLY TO ANOTHER PHYSICIANS OFFICE IS A FLAT FEE OF $22.80.

I UNDERSTAND THE MEDICAL RECORD TO WHOM THIS AUTHORIZATION IS FURNISHED MAY NOT CONDITION ITS TREATMENT OF ME ON WHEATHER OR NOT I SIGN THE AUTHORZATION. I UNDERSTAND THAT I AM NOT REQUIRED TO SIGN THIS AUTHORIZATION AND THAT THIS CONTENT MAY BE REVOKED IN WRITING AT ANYTIME. WITH THE EXCEPTION TO THE EXTENT THAT DISCLOSURE OF PHI HAS ALREADY OCCURRED PRIOR TO THE RECIEPT OF REVOCATION THE NAMED PROVIDER. THE INITIATE REVOCATION OF THIS AUTHORIZATION A DIRECT WRITTEN CORRESPONSENCE MUST BNE SENT TO THE HEALTH CARE PRVIDER ABOVE WITHIN 30 DAYS FROM THE REQUEST

I CERTIFY THAT I HAVE READ, AGGREED, SIGNED AND RECEIVED A COPY OF THIS AUTHORIZATION UPON MY REQUEST.

_____ _____ _____

(SIGNATURE) (DATE) (RELATIONSHIP TO PATIENT)