

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

AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION

PLEASE COMPLETE ALL SECTIONS 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, 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)

<input type="checkbox"/> ENTIRE MEDICAL RECORD	<input type="checkbox"/> PATHOLOGY REPORTS	<input type="checkbox"/> EKG/EEG
<input type="checkbox"/> HISTORY AND PHYSICAL	<input type="checkbox"/> BILLING RECORDS	<input type="checkbox"/> LABS
<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> OPERATIVE REPORTS	<input type="checkbox"/> ALL RECORDS
<input type="checkbox"/> CONSULTATION NOTES	<input type="checkbox"/> X-RAYS	<input type="checkbox"/> OTHER: _____

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

<input type="checkbox"/> HIV/AIDS RELATED INFO	<input type="checkbox"/> MENTAL HEALTH & PHSYCH INFO	<input type="checkbox"/> GENETIC INFO
<input type="checkbox"/> DRUG & ALCOHOL INFO	<input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE INFO	<input type="checkbox"/> TUBERCULOSIS INFO

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

<input type="checkbox"/> MYSELF (THE PATIENT OR GAURDIAN)	<input type="checkbox"/> OTHER
NAME: _____	NAME: _____
ADDRESS: _____	ADDRESS: _____

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

<input type="checkbox"/> MYSELF (THE PATIENT OR GAURDIAN)	<input type="checkbox"/> 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 AUTHORIZATION. 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 RECIPT 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)