COMPREHENSIVE PRIMARY CARE
HEALTHCARE WITH COMPASSION

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 ASK THE FRONT DESK.

PATIENT'S NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____
PHONE NUMBER: _____

I HEREBY REQUEST THAT COMPREHENSIVE PRIMARY CARE & ASSOSCIATES, LLC
15825 SHADY GROVE RD 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 MATTER, ANY AND ALL PORTIONS DESIRED BY THEM OF THE FOLLOWING:

PLEASE INCLUDE PHI DATE RANGE TO BE RELEASE: _____

DESCRIPTION OF PHI TO BE RELEASE (CHECK ALL THAT APPLY):

__ENTIRE MEDICAL RECORD __CONSULTATION NOTES __LAB/EKG REPORTS
__PRESCRIPTION RECORD __RADIOLOGY REPORTS __BILLING RECORDS
OTHERS (SPECIFY): _____

PLEASE SEND THE RECORDS LISTED ABOVE TO:
__ **MYSELF** NAME OF PATIENT: _____
ADDRESS: _____

OR

__ **DOCTOR NAME/FACILITY NAME:** _____
ADDRESS: _____
PHONE NUMBER: _____ FAX NUMBER: _____

THIS IS A PATIENT REQUEST, THE PATIENT WILL BE CHARGED FOR THE MEDICAL RECORDS UNLESS OTHERWISE NOTED, FEE: $0.76 PER PAGE (IF THE PATIENT IS REQUESTING) AND FULFILLMENT FEE (ACTUAL POSTAGE), THERE WILL BE A $22.88 ADMINISTRATION FEE FOR YOUR RECORDS TO BE TRANSFERRED TO ANOTHER PHYSICIAN.

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 CONTACT MAY BE REVOKED IN WRITING AT ANY TIME WITH THE EXCEPTION TO THE EXTENT THAT DISCLOSURE OF PHI HAS ALREADY OCCURRED PRIOR TO THE RECEIPT OF REVOCATION BY THE NAMED PROVIDER. TO INITIATE REVOCATION OF THIS AUTHORIZATION A DIRECT WRITTEN CORRESPONDENCE MUST BE SENT TO THE HEALTH CARE PROVIDER ABOVE, WITHIN 3- DAYS FROM THE REQUEST.

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

PATIENT'S SIGNATURE: _____ DATE: _____