



P.O. Box 191 Princess Anne, MD 21853
410-651-9852 410-651-1279 (FAX)

Authorization for Release of Medical Records

Patient's name _____ DOB _____ SS# _____

Address _____ Phone _____

1. Persons or group of persons authorized to **use/disclose** this information and purpose:

<input type="checkbox"/> Three Lower Counties Community Services, Inc.	Purpose:	<input type="checkbox"/> My personal health records
<input type="checkbox"/> _____ Name of physician/provider		<input type="checkbox"/> Transferring to another provider
_____		<input type="checkbox"/> Sharing information with another provider
Street _____ State _____ Zip _____		<input type="checkbox"/> Other _____

2. Persons or group of persons authorized to **receive** this information:

<input type="checkbox"/> Three Lower Counties Community Services, Inc.	<input type="checkbox"/> Me
<input type="checkbox"/> _____ Name	
Street _____ State _____ Zip _____	Telephone _____ Fax _____

3. Description of information to be used or disclosed: *(Please mark box with an X)*

<input type="checkbox"/> Copies by mail	<input type="checkbox"/> Records of health care	<input type="checkbox"/> Mental Health records	<input type="checkbox"/> HIV information	<input type="checkbox"/> Shot records
<input type="checkbox"/> Dental records	<input type="checkbox"/> X-ray & other images	<input type="checkbox"/> All		

4. ***This section must be completed if request for disclosure is made by someone other than the above-named patient:***

<p>Purpose for disclosure:</p> <p>I understand that the person I am authorizing to use/disclose my protected health information may receive compensation for doing so. _____ (patient initials)</p> <p>I understand that I may refuse to sign this authorization and that if I do, it will not affect my ability to obtain treatment or payment or eligibility for benefits and that I may inspect or copy any information used or disclosed under this authorization. _____ (patient initials)</p>

5. I understand that if the party receiving this information is not a health care provider or health plan subject to the federal privacy regulations that the information described above may be redisclosed and no longer protected by the privacy regulations.
_____ (patient's initials)

6. I understand that I may revoke this authorization in writing at any time except to the extent that action on this authorization has not already occurred.

7. This authorization becomes effective _____ and will expire on _____.
Date Date

_____	_____	_____
Patient (or Representative) Signature	Relationship to Patient	Date
_____	_____	
Witness Signature	Date	