Maryland Perinatal Associates

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Authorization to Release Protected Health Information

Patient name: _____

Last **First** **Middle**

Home address: _____

_____

Home telephone: **Date of birth:**

Social security number: - -

Specify information to be disclosed: (i.e., medical records, only billing records, only certain dates):

_____

Recipient: (name of person(s) to whom protected health information may be disclosed):

_____

Purpose of use or disclosure: (i.e., personal use, treatment, individual request, etc.):

_____

Term: This authorization shall not expire.

Please mark below if you specifically authorize the release of the following types of protected health information.

Check applicable boxes:

- ❒ Sexually transmitted disease (STD)
- ❒ AIDS/HIV
- ❒ Genetic information
- ❒ Behavioral or mental health services
- ❒ Alcohol or substance abuse
- ❒ Child abuse/domestic abuse

Pursuant to HIPAA Privacy Rules, I/authorized representative acknowledge the right to revoke this authorization at any time. It is understood that revocation of this authorization must be done in writing and presented to the healthcare provider named above; the revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.