MONOCACY HEALTH PARTNERS
PARKVIEW MEDICAL GROUP

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Parkview Medical Group

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

Patient Name _____ **Date of Birth** _____
(Please print clearly & list any previous names)

Patient Address _____

Phone (home) _____**(other)** _____

For Security, records may not be disclosed via email. I authorize the use or disclosure of the above named individual's health information as described below:

Release Records FROM: *When faxing records to Parkview please use this form as the cover sheet.*	☐ _____ (facility name) Address _____ _____ Phone _____ Fax _____
Release Records TO:	☐ _____ (facility name) Address _____ _____ Phone _____ Fax _____ ☐ If records are being released to self, please check here if you want the envelope marked "Personal and Confidential" ☐ Paper Copies ☐ Electronic Copy (Zip Drive) ☐ Patient Portal (if enrolled)
Information to be Released or Reviewed	The following Information is to be released (check appropriate boxes): ☐ History and Physical Exam ☐ Radiology Reports (films obtained from Radiology) ☐ Office visits ☐ Drug, Alcohol, or HIV ☐ Lab/Pathology reports ☐ Other: please specify _____ _____ ☐ Immunization records ☐ Entire Record Treatment Dates _____
Purpose for Disclosure	I would like this information released for the following purposes: ☐ Transfer to another primary care provider ☐ Continued care by another provider ☐ Personal Use ☐ Legal ☐ Other _____

I have read and understood the following:

- Parkview Medical Group, an affiliate of Frederick Regional Healthcare System, will release all records of treatment for mental health, chemical dependence, alcohol and/or drug abuse (as protected under the regulations of 42 CFR Part 2), sickle cell anemia, genetic conditions, AIDS/HIV and communicable diseases (as defined by Maryland statute and Department of Public Health rules). If I do not want a part of these records to be released, I do so, by indicating what specific records should not be included: _____.

- I understand this authorization shall expire in one year from the date noted below. I may revoke (cancel) this authorization at any time except to the extent that action has already been taken to comply with it. Revocations (cancellations) must be made in writing and sent to Parkview Medical Group at the address listed on this form. Revocations (cancellations) will not apply to information that has already been released.

- This authorization expires one year after I sign it or sooner (specify here: _____) the time period noted here may exceed one year only in certain situations specified by law.

- There may be a fee for releasing these records which is in accordance with Maryland law. (Note: Our current fee is $.76 a page. A $22.88 processing fee may also be charged). These fees are equal or less than the standard fees allowable by law. Parkview Medical Group may use a contracted vendor to process medical records requests. This vendor adheres to HIPAA Privacy and Security Standards.

- Once records are released, Parkview Medical Group cannot prevent them from being released to a third party.

- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.

_____ _____

Signature of Patient Date

_____ _____

Authorized Representative Date

_____ _____

Print Name Relationship to Patient; (parent, guardian, power of attorney, etc) (If authorized person is signing, please also print name)

ID checked/verified by PMG _____

Reason patient is unable to sign:

☐ Minor ☐ Deceased ☐ Other

Witness Signature _____

Date _____