Authorization for the Release of Protected Health Information

Patient Name: _____ _____
First Last
Address: _____
Street
_____
City State Zip
Phone: _____

I hereby authorize Dr _____
to release my Protected Health Information to:

Tammi Davis, M.D.
9199 Reisterstown Road, Suite 203B, Owings Mills, MD 21117 . Fax # 410-902-1933
By ____ Fax ____Mail

Purpose of Disclosure: ___Consultation

Information To Be Released:
____ Medical records (ED, H/P, Op Report, Consults, Labs, X rays, Consult notes, Pathology)
____ Specific visit notes _____ Labs ____ Consult reports ____ Path report
____ Other _____
____ Records to include diagnosis, care, treatments, labs, imaging studies, consults, procedures pertaining to the diagnosis of : _____

To Request the Release of Specifically protected or privileged information, you must initial below:
___ Psychiatric Records or Information ___ Professional Services of a Licensed Psychologist
___ Alcohol or Drug Abuse _____ Psychiatric Diagnosis/Medication List (but no visit records)
___ Eating disorder diagnosis/treatments/Medication list ____ HIV related records

TO REQUEST THE RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION, YOU MUST INITIAL BELOW:
_____ HIV Test Results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST).
_____ Sexually Transmitted Disease (STDS)
_____ Genetic Counseling
You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. I have been asked to provide a copy of your entire clinical record including my office notes, lab results, problem list, treatment plans , notes from consultants

Name _____ Date _____

and tests, and summaries. By signing this Agreement, you agree that I can provide requested information to your carrier.

I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Tammi Davis.
I understand that authorizing the disclosure of this health information is voluntary. If I fail to specify an expiration date or event, and unless otherwise revoked, this authorization will expire 12 months from the date of the signature listed below. I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of my condition to those persons or agencies listed above.

_____ _____

Signature of Patient **Date**