AAMG Annapolis OB-GYN

Authorization for Disclosure of Protected Health Information

Name of Patient _____ DOB _____
Please Print

Patient's Address _____
Street Address City State Zip

Information Requested _____

Reason : ( ) Consultation with Specialist ( ) Request by Insurance Co ( ) Moving ( ) Personal Record
( ) For Primary Care Physician ( ) Infertility Referral ( ) Leaving Practice Displeased ( ) Other
( ) Leaving Practice -Ins. Change - Name of New Insurance company _____

Purpose _____

Forward my records to: _____
Name (please print)

_____
Street Address City State Zip

Phone No._____ Fax No: _____

Forwarding Instructions:_____

_____

This authorization is effective immediately and will remain in effect for one year from the date of signature unless otherwise specified. This authorization is also subject to written revocation by the patient at any time and written revocation will be effective upon receipt. I understand that I have the right to receive a copy of this authorization. I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the process of copying my records will not begin unless I have given my credit card information and approval to charge my account. When the process is completed, I have the option of paying by credit card, cash or check. I understand that the charge for this service is $.76/page, and actual postage if I want the copies mailed to me. I understand that I will be responsible for payment in full even if I decide not to receive these records. Annapolis OB-GYN limits the use of fax machines for the transmission of medical records. Please allow (10) business days for the preparation of your records. Annapolis OB-GYN will not receive payment from a third party in exchange for using or disclosing the PHI. Format: Paper_____ Electronic_____

Credit Card No:_____ (Circle One) VISA MASTERCARD Security Code:____

Credit Card Exp. Date_____ Name on Card:_____

I do not have to sign this authorization in order to receive treatment from Annapolis OB-GYN. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule.

_____ _____
Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____
Date

Transfer of Records Request Updated 03/11/2020

FOR INTERNAL PURPOSES ONLY:

Fax Completed Form to: 443-837-2790
Or Mail to: 2000 Medical Parkway, Ste. 304, Annapolis, MD 21401