

AAMG Annapolis OB-GYN

Authorization for Disclosure of Protected Health Information

Name of Patient _____ DOB _____

Information Requested: _____

Reason/ Purpose of Request: _____

Forward my records to: _____

Address: _____

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

FOR INTERNAL PURPOSES ONLY:

Transfer of Records Request Updated 7/29/2020

Fax Completed Form to: 667-204-7240
Or Mail to: 2000 Medical Parkway, Ste. 304, Annapolis, MD 21401