PCA Primary Care
❑ 400 Eastern Shore Drive, Suites 203 & 204 Salisbury, MD 21804 Tel: (410) 543-8240, Fax: (410) 543-8640
❑ 314 Franklin Avenue, Suite 403 Berlin, MD Tel: (410) 629-1995, Fax: (410) 629-1993

Authorization for Use and Disclosure of Health Information

PATIENT NAME *(First, Middle, Last)*	DATE OF BIRTH (*MM, DD, YYYY)*	
ADDRESS (Street, City, State, Zip Code)		
TELEPHONE	CELL PHONE	SOCIAL SECURITY NUMBER XXX-XX-_____

*** I request that my Protected Health Information (PHI) from _____ be disclosed to:**

RECIPIENT NAME:
ADDRESS (Street, City, State, Zip Code)
FAX (Healthcare provider only):

I authorize the following PHI to be released from my medical record:

❑ Discharge Summary
❑ History and Physical
❑ Operative Report
❑ Test Results Date: _____ Type: _____
❑ Emergency Room Record Date: _____
❑ Consultation Reports Date: _____
❑ Radiology Report Date: _____
❑ Laboratory Report Date: _____
❑ EKG Report Date: _____
❑ Billing Statements Date: _____
❑ Abstract (*Patient Demographics, Discharge Summary, History & Physical, Operative/Procedure Note, Labs, Radiology and Pathology*)

Covering period of healthcare from _____ to _____2014.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released.

Alcohol, Drug, or Substance Abuse Records	❑ Yes	❑ No	Dates: _____
HIV Testing and Results	❑ Yes	❑ No	Dates: _____
Mental Health or Psychotherapy Records:	❑ Yes	❑ No	Dates: _____

Purpose for requesting information:
☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care ☐ Transferring Care to Another Practice

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Supervisor, Front Office, Peninsula Cardiology Associates, P.A. 400 Eastern Shore Drive, Salisbury, MD 21804. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will ***expire on the following date/event/condition***: _____
- If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

_____ ____/____/____ _____ ____/____/____
(Signature of Patient) (Date) (Signature of Witness) (Date)