EASTERN SHORE PRIMARY CARE
EXCEPTIONAL PREVENTATIVE AND MANAGED CARE

7416 Church Hill Road, Suite 2
Chestertown, MD 21620
P: (410) 758-2178 F: (667) 254-8190

Medical Record Release Authorization Form

Patient's Name: ____

Date of Birth: ______________________

Authorization:

I, the undersigned, hereby authorize the release of my medical records to the following individual or entity:

Name of Recipient: **Eastern Shore Primary Care**

Address: **7416 Church Hill Road, Suite 2, Chestertown MD 21620**

Phone Number: **(410)758-2178**

Fax Number (if applicable): **(667)254-8190**

Purpose of Release:

Please specify the purpose of the release of the medical records (e.g., for personal records, to another healthcare provider, for insurance purposes, etc.):

Purpose: ____

Records to be Released:

Please check the box next to the specific medical records you wish to release:

[ ] Entire Medical Record

[ ] Specific Date Range: From ______________ To ______________

[ ] Specific Information or Documents (describe):

HIPAA and Privacy Act Information:

I understand that my medical records may contain sensitive and protected health information (PHI) governed by the Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Act. I authorize this release in accordance with these regulations.

Revocation:

I understand that I have the right to revoke this authorization at any time by providing written notice to Eastern Shore Primary Care. I understand that the revocation will not apply to information that has already been disclosed in reliance on this authorization.

Patient's Signature: ________________________________ Date: ______________

Parent/Guardian Signature (if applicable):

I, as the parent or legal guardian of the patient, hereby authorize this release on their behalf.

Parent/Guardian's Name (print): __________________________________

Parent/Guardian's Signature: ____________________________________