Luminis Health OB/GYN – Annapolis
Authorization For Disclosure of Protected Health Information

Patient's Name: ______________________________ DOB: ____________________________

Patient's Current Address: ____

Information Requested: ____

Reason/Purpose of Request – (please select all that apply)

- For Primary Care Physician
- Requested by Insurance Company
- Leaving Practice due to ____________________________
- Other (please specify) ____________________________

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. Luminis Health OB/GYN - Annapolis limits the use of fax machines for the transmission of medical records. Please allow (10) business days for the preparation of your records. Luminis Health OB/GYN - Annapolis will not receive payment from a third party in exchange for using or disclosing the PHI. Format: Paper_ ______Electronic_ _______

Visa or MasterCard Number: _______-______-_______-_______ Expiration Date: ______/____________

Security Code: ________

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.

Patient or Legal Guardian Signature: ______________________________ Printed Name: __________________________

Date: ____________________________

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