Patient Authorization for the Release of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____
Address: _____ Today's Date: _____
_____ Phone: _____

I HEREBY AUTHORIZE THE DISCLOSURE AND USE OF MY HEALTH INFORMATION

O From and/or O To: Dr. Ayanna Cooke-Chen, c/o Children First MD, LLC
57 W. Timonium Rd.
Suite 215
Timonium, MD 21093
Phone: 443-546-5350 Fax: 443-457-2301

O From and/or O To: _____
Name
_____
Address
_____ _____
Phone Fax

DATES OF RECORDS/INFORMATION: FROM: _____ TO: _____
PURPOSE OF AUTHORIZATION: ☐ Patient Care ☐ Academic ☐ Personal ☐ Legal ☐ Insurance/Payment ☐ Other

TYPES OF RECORD(S) INFORMATION: O Initial Assessment O Medication Log O Labs/Studies O Visit/Progress Note(s)

O Mental Health Record(s) (except psychotherapy notes) O Psychological/Educational Testing O Academic/IEP

O Discharge Summary O Psychiatric and/or Medical Hospital Discharge Summary O Other _____

If the information includes records or information from another health care provider or entity, that information:

O should or O should not be released under this Authorization.

METHOD OF DISCLOSURE Please release my records/information via: O Mail O Fax O Pick-up by patient O Verbal
Please note: 1. Faxing may compromise your privacy. 2. CFMD, LLC may charge for copying, which I agree to pay.

EXPIRATION OF AUTHORIZATION [Insert defined event or date not later than one year from the date Authorization is signed] This Authorization will expire on: _____.

I understand that when the information is disclosed to someone who is not required to comply with federal/state privacy protection requirements, it may be subject to re-disclosure by the recipient and may no longer be protected. This Authorization is voluntary and I retain the right to revoke it at any time; my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have already acted in reliance on this Authorization. In order for my revocation to be effective, it must be in writing. A revocation is not effective until the later of the date it is received by the entity or any other date specified in the revocation. My treatment is not conditioned on my signing this form. I may receive a copy of this form. I have the right to inspect or copy my PHI to be used or disclosed pursuant to this Authorization, as permitted by law. I may inspect my protected health information without signing this form. I understand that medical information released may contain information related to HIV/AIDS status, sexually transmitted diseases, pregnancy/abortion, and drug and alcohol abuse. I AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PHI AS DESCRIBED ABOVE. I HAVE READ THE CONTENTS OF THIS AUTHORIZATION, AND I FULLY UNDERSTAND AND ACCEPT ITS TERMS.

_____ _____
Patient or Personal Representative Signature Date

_____ _____
Print Name of Personal Representative Relationship to Patient