Anne Arundel Gastroenterology Associates, P.A.

Bestgate Medical Clinic
820 Bestgate Road, Suite 2A
Annapolis, Maryland 21401
410-224-2116 Fax 410-224-2118

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

1. Regarding Patient (*COMPLETE IN FULL*)

Name - Last, First, MI			
Street Address			
City	State	Zip Code	Home Telephone #
Social Security #	Birth Date		Work Telephone #
Records Released From (Physician's Name)			

2. Records Released To

Name - (i.e. Insurance Co., Lawyer, Physician, Self)				
Street Address				
City	State	Zip Code	Telephone #	Fax #

3. INFORMATION TO BE RELEASED:

- ☐ Complete Copy of All Records
- ☐ Lab Reports
- ☐ Pathology Reports
- ☐ Procedure Reports
- ☐ Medical Office Notes
- ☐ Radiology Reports
- ☐ Itemized Billing Information
- ☐ Other (Specify)

FOR THE FOLLOWING DATES:

* Special Authorization which requires permission to release otherwise privileged information, please release records pertaining to:
(Check applicable conditions)

- ☐ Mental Health
- ☐ Developmental Disabilities
- ☐ Alcohol Treatment/Evaluation
- ☐ Aids/Aids-Related Illness
- ☐ Drug Treatment/Evaluation
- ☐ HIV Test Results

4. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

- ☐ Further Medical Care
- ☐ Payment of Insurance Claim
- ☐ Application for Insurance
- ☐ Legal Investigation
- ☐ Personal
- ☐ Disability
- ☐ Relocating
- ☐ Other:

5. I WOULD LIKE TO RECEIVE MY RECORDS VIA:

- ☐ Patient Portal (no charge)
- ☐ USB(unencrypted) ($25.00) *please make check payable to AAGA*
- ☐ Hard Copy ($.76/per page + $22.88 administrative fee) *fees will be calculated and you will be mailed an invoice*

5. I authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original. This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period.

6. Signature of patient: ______________________________ **Date:** ____________

(If signed by person other than patient, state relationship and authority to do so.)

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Anne Arundel Gastroenterology Associates, P. A. honor a patients right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to sign. You are under no obligation to sign this form and you may refuse to do so. Except as permitted under applicable law, AAGA may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any times before it ends. However, your written revocation will not affect any disclosure of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effect in certain circumstances where the Insurer is contesting a claim. Your revocation must be made in writing and addressed to: Privacy Officer, AAGA, 820 Bestgate Road, Suite 2B, Annapolis, Maryland 21401.

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws and those people may be permitted to re-release your medical information without your prior permission.

Right to inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing in accordance with requirements of federal privacy protection regulations found under copying fees. If you are requesting disclosure/release of medical information to other hospitals, clinics or physicians for further medical care, no copying fees will be charged. You must pay for copies you request for other reasons.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply.