Frederick Primary Care Associates | PRIVIA MEDICAL GROUP

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name _____ **Patient's Date of Birth** _____

Address _____ **Patient's Telephone Number** _____

City, State Zip Code _____ **Any Other Names Used** _____

I hereby request that Privia Medical Group use / disclose my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):
   _____
2. Be sent to the following person / entity at the address listed below:
   Name _____
   Address _____
   City _____ **State** _____ **Zip Code** _____
3. I hereby authorize disclosure of the following information: ☐ My entire medical record; ☐ Immunization Records Only ☐ Service Dates Only: _____ to _____
   ☐ Specific Information Only:
   _____
   _____
   _____

NOTES: 1) INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH IS INCLUDED UNLESS YOU SPECIFICALLY REQUEST THAT IT BE EXCLUDED. 2) IF YOU REQUEST RECORDS BE SENT TO A TREATING PROVIDER AND YOU DO NOT WANT YOUR ENTIRE RECORD SENT, WE WILL SEND YOUR RECORDS TO YOU FOR DELIVERY TO YOUR PROVIDER; WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.
☐ **PLEASE EXCLUDE THE FOLLOWING INFORMATION:**
_____

4. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **If I do not specify a format below, I understand that my PHI will be provided in paper format**.
5. **I hereby request that my PHI be provided in the following format:** ☐ via secure electronic delivery; ☐ on an encrypted USB drive ☐ on an **un**encrypted USB drive ☐ other (please specify) _____.
6. If I have requested records be sent **un**encrypted, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
7. If I requested records on a USB drive, I understand I will be charged for the cost of the USB drive.
8. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and would then no longer be protected by federal privacy regulations.
9. I understand I may revoke this authorization by notifying Privia Medical Group in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
10. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify) _____.
11. This authorization expires on _____ _____, 20 _____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please specify) _____.

FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI If a summary or explanation was requested, and postage. If the charges will exceed $25, we will inform you of the approximate charges prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

Signature of Patient	Date of Patient's Signature	Patient's Date of Birth

If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate	Date of Legal Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual

For Privia Use Only

Date Received	Date Processed	Format	Fee	Pt Notified of Fee	Medical Record #