Matthew Mardiney, MD
ADVANCED
ALLERGY & ASTHMA
CENTERS

ATTENTION: MEDICAL RECORDS
1300 York Road, Suite 30D
Lutherville, MD 21093
Phone: 443-519-2128
Fax: 443-557-6699

Authorization for Use and Disclosure of Protected Health Information

Name of Patient (First, Middle, Last) _____ Maiden or Previous Name _____ Date of Birth _____

Address _____ Apt ____ City _____ State ___ Zip _____

Phone (Home) _____ Phone (Work) _____ Phone (Cell) _____

AUTHORIZE:

Name of Physician / Healthcare Facility _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

RELEASE RECORDS TO:

Name of Physician / Healthcare Facility _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Information to be Released

Date Range: From _____ To _____

❑ Progress Notes ❑ Consultation(s) ❑ Laboratory Results ❑ Immunotherapy Records/Formulation ❑ X-ray/Radiology Reports

❑ Other: _____

Reason for Disclosure

I would like this information released for the following purpose (s):

❑ Continued care by another provider ❑ Attorney ❑ Insurance Purposes ❑ Social Security/Disability ❑ Personal Use

❑ Other: _____

If leaving our clinic (s) - Reason

❑ Dissatisfaction ❑ Moving ❑ Insurance ❑ Convenience of Hours/Location

❑ Other _____

I have read and understand the following:

** This authorization expires one year after I sign it or someone else (specify here _____). This time period noted here may exceed one year only in certain situations specified by law.*

** I may revoke this authorization at any time by notifying the facility in writing that I have authorized to release my records and this authorization will cease to be effective on the date notified. This will not apply to records that have already been released.*

** The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations. However, other state and federal law may prohibit the recipient from disclosing specially protected information. Once the records are released, we can nor prevent them from being released to a third party.*

** There may be a fee for releasing these records.*

Name of Patient or Authorized Party** (Print) Signature of Patient or Authorized Party Date

***Parent, Guardian, Power of Attorney, etc.*