

AUTHORIZATION FOR USE and DISCLOSURE OF INFORMATION

I am a patient of ENTAA Care, P.A. and hereby authorize ENTAA Care to use, obtain, review and disclose my individually identifiable health information for the purpose stated herein. I understand that this authorization is voluntary and I may refuse to sign this authorization.

Please Check One of The Following:

(Records will be ready within 3-10 business days)

Medical Records to be released to self is .76 cents per page; (this includes paper or electronic format) plus the cost of postage.

OR

Medical records to be released to another provider, there will be a flat fee of \$22.88 to the patient.

PAYMENT METHOD:	<input type="checkbox"/> CASH	<input type="checkbox"/> CHECK # _____	<input type="checkbox"/> CHARGE (VISA/MC, AMEX, DISC)
DATE OF PAYMENT: ____/____/____	Number of Pages _____	TOTAL FEE \$ _____	

Picked up at: Annapolis Baltimore Columbia Glen Burnie Kent Island Laurel Odenton

Please Complete All of the Following Information

Name of Patient at ENTAA Care: _____ DOB: ____/____/____

Party to Whom Information Will Be Disclosed to:

Address of Whom Records Will Be Disclosed to:

Self
OR
 Other: _____

Name _____

Street Address _____

Party Authorized to Make The Use of Disclosure:

City _____ State _____ Zip Code _____

ENTAA CARE

Phone Number _____ Fax Number _____

Medical Records or Patient Information to Be Released:

Entire Record OR Description of Information to Be Released: _____

If ENTAA Care possesses records from another provider or facility I do I do NOT (check one) wish to have those records released under this authorization. Initials: _____

The Patient or the Patient's Legal Representative Must Read and Initial All of the Following Statements:

- a. I understand that the patient's health care and the payment for his/her health care will not be affected if this form is not signed. Initials: _____
- b. I understand that this release form is valid for 1 year from today's date, unless the patient prefers that release expires sooner ____/____/____. (DD/MM/YY) Initials: _____
- c. I understand that I may revoke this authorization at any time by notifying ENTAA Care in writing. If I do it will not affect any actions taken before ENTAA Care received the revocation. Initials: _____
- d. I understand that the information may be redisclosed by ENTAA Care. Initials: _____

Signature of Patient or Patient's Legal Representative _____

Date _____

Print Name of Patient's Legal Representative: _____

Relationship to the Patient: _____

Please review the Notice of Privacy Practices concerning your rights.