

FEES FOR COPYING PATIENT RECORDS

Total Cost Includes:

- Preparation fee \$22.00
- \$0.73 per page

Please allow 5 to 10 business days for records to be copied.

You will be mailed an invoice with your fee amount after the records have been copied.

Payment can be made with cash, check, Visa or MasterCard and it can be brought in, mailed in or made over the phone.

Prepayment is required prior to records being released and must be done within 30 days of records being copied.

We **do not fax** complete medical records due to HIPPA Regulations and we highly recommend patients pick them up to ensure proper receipt of records.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name Birth date (Mo/Day/Yr)

Street Address Social Security Number

City, State, Zip code Phone

I authorize Digestive Disorders Associates to release my medical records as specified below:

All Medical Records Office visit notes 24 HR PH/Manometry/Motility/Remicade
 Laboratory Reports Radiology Reports Colonoscopy/EGD/EUS/ERCP Report
 Pathology Reports Other (specify) _____

Service Date(s): For the last: 5 years 2 years 6 Months Other _____ year(s)/month(s)
OR From _____ to _____

I do I do NOT authorize release of information related to AIDS(Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

REASON FOR REQUEST

Referral to Specialist Insurance Workers Comp Legal Investigation
 Disability Determination Personal Out of State Move Change GI Dr
 Other (specify) _____

Name of Individual or Organization: _____
Street Address: _____
City, State, Zip Code: _____

DELIVERY METHOD: (please check one)

Patient/Designee to pick up records. Designee Name: (if other than patient) _____
 Mail to patient
 Mail to organization/individual address listed above

I understand I have the right to revoke this authorization at any time and that I must do so in writing and present my written authorization to Digestive Disorders Associates. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand my revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise specified, this authorization will automatically expire in one year.

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of my information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Privacy Officer for Digestive Disorders Associates at 410-224-4887.

Signature of patient, guardian or Date
Personal Representative of patient's estate

NOTE: Per Maryland law, Health-General Article Section 4-304(c)(3) as of 2004 physicians are allowed to charge specific sums for and production of medical records that is adjusted annually for inflation. Please refer to MedChi.org for current fee amounts. All records have to be paid for prior to them being released and we highly recommend copies be picked up and hand carried by patients instead of them being mailed to ensure proper receipt of records.