ENTAA Care, P.A.
203 Hospital Drive, Suite 200, Glen Burnie, MD 21061 • Phone 410-760-8840 • Fax 410-760-8847 • entaacare.com

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: ❑ **CASH** ❑ **CHECK #**_____ ❑ **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:

❑ Self

OR

❑ Other: _____

Party Authorized to Make The Use of Disclosure:

ENTAA CARE

Address of Whom Records Will Be Disclosed to:

_____
Name

_____
Street Address

_____
City State Zip Code

_____
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.