Maryland
DEPARTMENT OF HEALTH

Request for Access to Records Form

Purpose: This form is used to confirm the direction of an individual to authorize Maryland Department of Health to request, to use, or to disclose the individual's health information.

PLEASE PRINT LEGIBLY; we are not able to process incomplete or illegible forms.
**** Indicates mandatory fields***

***SECTION A: IDENTITY OF THE REQUESTOR OF INDIVIDUAL'S HEALTH INFORMATION (CHECK ONE)**

☐ Patient (Adult)
☐ Patient (Minor Consent)
☐ Parent of Minor Child
☐ Guardian of Minor Child
☐ Parent/Guardian authorized to consent to healthcare (Adult)
☐ OTHER _____

Requestor (Self): _____ Phone: _____

Address: _____ Fax: _____
(Must be a secured fax machine)

SECTION B: INDIVIDUAL'S HEALTH INFORMATION AUTHORIZED FOR USE AND DISCLOSURE

*Last Name: _____ *First Name: _____ Ml: _____ *Date of Birth: _____

*Street Address: _____ Apt #: _____

*City: _____ *State: _____ *Zip:_____

Phone: (home) _____ (work) _____

SECTION C: DISCLOSURE BEING AUTHORIZED

1. Provide a detailed description of the health information you are authorizing us to disclose.

_____

_____

_____

2. The purpose of the disclosure: _____

_____

_____

SECTION D: EXPIRATION AND REVOCATION
(IF THIS SECTION IS NOT COMPLETED, THE LABORATORIES ADMINISTRATION CANNOT ACCEPT THIS FORM.)

Expiration: This authorization will expire one year from today's date unless otherwise noted (complete one):

☐ ONE YEAR FROM TODAY'S DATE: _____

☐ On occurrence of the following event (which must relate to the individual or to the purpose for which the disclosure has been authorized): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Laboratories Administration. In order to obtain a revocation form to revoke this authorization, I understand that I may contact the Office of Regulatory and Administrative Services. I understand that revocation of this authorization will not affect any action that the Laboratories Administration or others named or unnamed took in reliance on this authorization before the Laboratories Administration received my written notice of revocation.

SECTION E: SIGNATURE

To the Individual – Please Read the Following:

I authorize the disclosure of my health information as described in sections C and D above. I understand this authorization is voluntary.

I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

Signature of Individual Requestor: _____ **Date:** _____

Printed Name of Individual Requestor: _____

Medical License Number (If Applicable): _____

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

Personal Representative's Name: _____ **Date:** _____

Relationship to Individual: _____

Please return this form via fax to (443) 681-4501 or via email to *mdlabs.recordsrequest@maryland.gov*

The Laboratories Administration is prohibited from conditioning the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on the requirement that a person in interest sign the authorization.