MARC L. CHAIKEN, M.D.P.A. & ASSOCIATES
11055 Little Patuxent Parkway Suite 106 Columbia, Maryland 21044
Tel: 410-730-6673 FAX 410-730-8226

AUTHORIZATION TO RELEASE INFORMATION
ALL ITEMS MUST BE COMPLETED
INCOMPLETE FORMS WILL NOT BE PROCESSED

I hereby authorize Marc L. Chaiken, M.D., P.A. to provide copies of the health information as indicated below covering the dates___/___/___to___/___/___.

Patient:____

Date of Birth:____

Address:____

Phone #:____

***What would you like to be released:**

____**All** Medical Records (entire chart)

____Billing Records

____Other (Be Specific – certain appts, labs, etc)______________________________

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***Are you requesting these records because you are transferring from Dr. Chaiken to a new gyn and will not be returning to our office:**

____Yes

____No

***The information is to be released to:**

Name:____

Address:____

If Marc L. Chaiken, M.D., P. A. maintains any of the following information, I do/do not Authorize its release as indicated below:

Please check one:

I do___ I do not___ authorize the release of information regarding HIV/AIDS
I do___ I do not___ authorize the release of psychotherapy notes
I do___ I do not___ authorize the release of information regarding drug/alcohol abuse

If Marc L. Chaiken M.D., P.A. is in possession of health information from another health care provider, I do___ I do not___ wish to have those records released under this authorization.

I understand that:

-Marc L. Chaiken, M.D., P.A. may charge a fee for the costs of copying and mailing associated with my request as well as for the preparation of any summary that I request.
-This authorization is voluntary.
-My treatment is not conditioned upon my signing this authorization.
-I may receive a copy of this authorization.
-Information disclosed pursuant to this authorization may be re-disclosed by the recipient listed above and such information may no longer be protected by HIPAA ;however, such information may be protected from re-disclosure by Maryland law.
-This authorization may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation.

_________________________________ _____________________

PATIENT'S SIGNATURE **DATE**

IF THE SIGNATURE ABOVE IS BY ANY INDIVIDUAL OTHER THAN THE PATIENT, PLEASE EXPLAIN YOUR AUTHORITY TO ACT FOR THE PATIENT.

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