PULSE CHIROPRACTIC
Move Freely. Live Fully.

MEDICAL RECORDS RELEASE FORM

PATIENT IDENTIFICATION

Patient Full Name: _____

Date of Birth: _____ Email Address: _____

Social Security Number: _____ Phone Number: _____

Address: _____

AUTHORIZATION FOR USE OR DISCLOSURE

By signing this document, I, the above-named, hereby grant permission for the use or disclosure of my health information as outlined below. I understand that this information may include records maintained by the healthcare provider concerning my physical or mental health or condition, treatment received, and billing records related to my healthcare.

I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive My Health Information by unencrypted e-mail, I am acknowledging and accepting these risks.

I understand there may be a fee for a copy of My Health Information. I understand that all fees will be in compliance with applicable law. I agree to pay this fee. Maryland law (Health General Sec. 4-304) allows physicians to charge patients (or the patient's "personal representative") a fee for copying medical records. The charges may be adjusted annually for inflation. Effective immediately, the fee remains as stated: A fee for copying not to exceed **$0.76 for each printed page and $0.57 per digital page** of the medical record; The actual cost of postage and handling; **Preparation fee of $22.88**, if the records are sent to another provider. The federal HIPAA regulations do not allow a charge for a preparation fee for records provided directly to the patient; A provider may not refuse to provide the records because of unpaid fees for medical services.

TYPE OF AUTHORIZATION

Please select one:

☐ **Comprehensive Disclosure**: I authorize the disclosure of all my health-related information.

☐ **Partial Disclosure**: I authorize the disclosure of only the following health-related information:

□ Complete record

□ Abstract (face sheet, history and physical, discharge summary, consult)

□ Diagnoses

□ Physical Therapy notes

□ Progress notes

☐ **Applicable Date Range**: Indicate the date range for which health information is relevant:

From: _____ To: _____

☐ **Other Disclosures:**

AUTHORIZED RECIPIENT INFORMATION

I designate the following individual or entity to receive the health information specified:

Name of Authorized Party: _____

Relationship to Patient (if applicable): _____

Organization (if applicable): _____

Phone Number: _____ Email Address: _____

Address: _____

I affirm that the Authorized Party named above is permitted to receive the health information as I have specified. This authorization does not permit further disclosure to additional parties unless specified and consented to by me in writing.

PURPOSE OF DISCLOSURE

The purpose for which I am authorizing disclosure:

☐ General healthcare operations ☐ Payment or billing ☐ Legal or insurance matters

☐ Other (Please specify): _____

EXPIRATION AND REVOCATION

This authorization shall remain valid until:

☐ A specific event occurs: _____

☐ Date: _____

I understand that I have the right to revoke this authorization at any time by submitting written notice to:

Name/Department: _____

Address: _____

RIGHTS AND ACKNOWLEDGMENTS

I acknowledge that:

☐ I have read and understand my rights under HIPAA.

☐ I am aware that I may refuse to sign this authorization.

☐ I am entitled to receive a copy of this authorization.

☐ I may inspect or copy the authorized information.

☐ My refusal will not affect my ability to obtain treatment except in cases where the authorization is required by law.

SIGNATURES

This authorization shall remain valid until:

Signature of Patient

Date

Print Name

If the patient is unable to sign, a legal representative may sign below:

Reason for patient's inability to sign:

Signature of Representative

Date

Print Name

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian

Other (Please specify):