AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Records To Be Released FROM:

Business Name:

Address:

City, State, Zip:

Telephone: **Fax:**

I Hereby request and authorize you to furnish records for the purpose of **continuity/ continuing care** or at my request. Release is from the **most recent visit** to present. Please include Labs, Radiology, Immunizations or ALL. (Please circle selection.)

Records To Be SENT To: Medical Records Coordinator

Business Name: BW Primary Care, LLC.

Address: 10084 Reisterstown Road, Suite 200A

City, State, Zip: Owings Mills, MD 21117

Telephone: 410-552-5050 Fax: 410-356-7505 or 410-552-0200

Patient Name: _____ **DOB:**

Address: _____ **City, State, Zip:**

Phone Number: _____ **SSN:**

I understand that:

1. I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it.
2. The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations.
3. I am entitled to a copy of this document.
4. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment or eligibility for benefits.
5. There may be a charge for the release of these records pursuant to 45 CFR 164.524 © (4) (HIPAA).
6. This authorization shall expire upon written request to revoke or according to state law.
7. A copy of this authorization is as valid as the original.

_____ **Date:** _____

Signature of Patient or Patient Representative

Medical Records Coordinator at BW Primary Care, LLC.

Description of Representative's Authority to Act for Patient