PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Advanced Menstrual Care Center LLC (AMCC): (**Select the appropriate following choice by initialing.**)

_____**To SEND copies** of my medical records to the following:

_____**To GET copies** of my medical records from the following:

Provide full name and mailing address, including phone and fax numbers

_____

_____

_____

I understand:

- My records may contain information about my diagnosis or treatment of medical, genetic, psychiatric, HIV, or alcohol and drug abuse conditions, as well as sexual or obstetric history, among others. It is usually not possible to remove any specific information from a medical record.
- I understand that any request to release "all" records is understood to mean the past 10 years.
- There may be a charge for the release of medical records. Maryland law on medical records can be found at https://health.maryland.gov/mbpme/Pages/records.aspx.
- When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
- Once the records are released, you acknowledge that AMCC no longer has responsibility for security or maintenance of those records.
- I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at AMCC., 1810J York Road, Timonium, MD 21093. 410-337-AMCC (2622), Fax 410-321-5493.

INFORMATION BEING REQUESTED (OR TO BE RELEASED):_____

_____

I do not wish to have the following information released. (Leave blank if there are no limitations.)

_____

Patient name_____DOB_____

Address_____

Home/Cell Phone_____Fax_____

Email:_____

Signature:_____Date_____

Typed/Written Name of Patient:_____