ENT PROFESSIONALS OF MARYLAND
EAR • NOSE • THROAT • HEAD & NECK SURGERY

ENT Professionals of Maryland LLC

Kenneth Wong, MD
Phone: 301-441-9330 | Fax: 301-238-7965
www.entpromd.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name:	DOB:
Address:	Phone:
City/St/Zip:	

The above individual is requesting that ENT Professionals of Maryland LLC release personal health information (*check one*) ☐ **TO** or obtain ☐ **FROM** the recipient(s) listed below:

Name:	
Address:	
Phone:	Fax:

The information to be disclosed relates to service date(s): _____

☐ All records	☐ Progress notes	☐ Surgical notes	☐ Test results	Other:
Please exclude the following:				

The purpose of the disclosure (*"Request of Individual" is sufficient for patient initiated releases*):

☐ Request of Individual	☐ Change of Doctor	☐ Legal
☐ Referral to Doctor	☐ Insurance	Other:

CONDITIONS and NOTIFICATIONS:
This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by giving written notification to the practice. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to ENT Professionals of Maryland LLC and all associated providers.
Note: There may be a preparation and handling fee charged to cover labor, copying, and supplies used to fulfill medical records requests pursuant to Health-General Article, §4-304, Annotated Code of Maryland.

SIGNATURES:
I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary, and that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that the information being disclosed may include medical diagnoses and/or treatment for drug or alcohol abuse, mental illness, or communicable diseases like HIV. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

_____ Signature of Patient or Parent/Guardian

_____ Date

_____ Print Name of Patient or Parent/Guardian

_____ Relationship (if Parent/Guardian)

Handling and preparation	$22.88
___ pgs x 0.6	$
Total	$