CMP Administration
5450 Knoll North Drive, Suite 215
Columbia, Maryland 21045
Ph: 410-964-8510 Fax: 410-964-8508

Authorization for Release of Protected Health Information by CMP

Patient Name: _____ **Date of Birth** ___ /___ /_____
(First) (Middle Initial) (Last)

Street Address: _____ **Phone #** _____

City: _____ **State** _____ **Zip Code:** _____

I hereby authorize Columbia Medical Practice to release the protected health information (PHI) identified below for dates of service from: _____ /_____ /_____ **to** _____ /_____ /_____ .

Information to be released:

___ **Complete Medical Record** ___ **Radiology Reports Only**

___ **Laboratory Reports Only** ___ **Other:** _____

Information to be excluded:

I understand that this authorization includes permission for CMP to release any PHI in my health record relating to the history, diagnosis, testing/results, or treatment that I may have received for sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, or treatment of alcohol, drug or substance abuse.

If any of this information is the record and is to be excluded, please check the box below for do not release:

Category	Do Not Release
Alcohol, Drug or Substance Abuse	
Behavioral/Mental Health	
Acquired Immunodeficiency Syndrome (AIDS)	
Human Immunodeficiency Virus (HIV)	
Sexually Transmitted Disease (STD)	

Purpose:

☐ Changing physician ☐ Consultation/ second opinion ☐ Legal

☐ School ☐ Insurance ☐ Other: _____

COLUMBIA MEDICAL PRACTICE

CMP Administration
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Columbia, Maryland 21045
Ph: 410-964-8510 Fax: 410-964-8508

Released to:

Name: _____

Organization: _____

Street _____City _____State _____Zip _____

Phone_____ Fax_____ Email _____

Specify Disclosure Format: Default = Secure Internet Download/PDF if not shown otherwise

☐ Secure Internet Download/PDF ☐ CD/Electronic/PDF for ____Mail or ___ Pickup

☐ Fax (Healthcare provider office only) ☐ Paper for ____ Mail or _____ Pickup

By signing this authorization form, I understand that:

1. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to:
   Columbia Medical Practice - Administration
   5450 Knoll North Drive, Suite 180
   Columbia, Maryland 21045.
2. Revocation will not apply to information that has already been disclosed in response to this authorization.
3. Unless otherwise revoked, this authorization will expire one year from the date signed.
4. Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.
5. Requests for copies of records are subject to preparation and copying fees in accordance with federal/state regulations.
6. Columbia Medical Practice may not condition your receipt of treatment on your signing of this Authorization.

Authorizing Party: I hereby authorize Columbia Medical Practice to release the PHI listed above from the medical records.

Signature _____ Date _____

Please complete if not the patient:

Name _____ Relationship _____

Signature _____ Date _____