AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(PURSUANT TO HIPAA, 45 CFR PARTS 160 AND 164)

TO: **Nancy C. Wheeler, M.D., P.A. 133 Defense Highway, Suite 114, Annapolis, MD 21401**

RE: Patient Name: _____
DOB: _____

I authorize and request the above-named facility/provider to use and disclose the protected health information described below to:

_____
_____
_____

I authorize the facility named to release my complete health record (including records relating to psychiatric treatment, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.) These records may include office notes, face sheets, history and physical, consultation notes, test results, medication record, documents and correspondence, and records received by other medical providers.

The medical information may be used by the person I authorize to receive this information for medical, psychiatric, or psychological treatment or consultation, billing or claims payment, or other purposes I direct.

I understand that the health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient unless the health information is protected under federal confidentiality rules 42CFR Part 2. I understand that once information is released, this facility cannot prevent the recipient from further disclosing the information.

This authorization shall be in force and effect until termination of treatment or _____ at which time this authorization expires.

I understand that signing this authorization is not required in order to receive treatment.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written a written request to Nancy C. Wheeler, M.D. at the above address. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____/_____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative and His/Her Relationship to Patient