Janene Martin, ND
410.296.4005 Tel
410.296.4636 Fax

2345 York Rd., Suite 102
Timonium, MD 21093

Authorization to Disclose Protected Health Information to Dr. Janene Martin, ND 2345 York Rd., Suite 102, Timonium, MD 21093

Date _____ **Patient's Date of Birth** _____
TODAY'S DATE

Patient's Name _____ _____ _____
FIRST MIDDLE LAST

Address _____
STREET CITY STATE ZIP

As required by the Privacy Regulations, Dr. Janene Martin may not use or disclose your protected health information except as provided in the Notice of Privacy Practices without your authorization.

I hereby authorize:

Doctor's Name _____

Address _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

Phone _____ _____
WORK FAX

to disclose my Patient Health Information to Dr. Janene Martin, ND

PLEASE: _____**FAX TO** **(410) 296-4636**

_____**MAIL TO** **2345 York Rd., Suite 102**
Timonium, MD 21093

By *initialing* the spaces below, I authorize the release of the following records, if such records exist:

_____**Laboratory report** _____**EKG**

_____**Pathology reports** _____**X-Ray**

_____**Operative report** _____**Entire medical record**

_____**Progress notes** _____**Other, please be specific:**_____

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Any of the following items must be initialed to be included in other documents:

_____**HIV/AIDS related record** _____**Mental health records**

_____**Drug/Alcohol diagnosis, treatment or referral information** _____**Genetic testing information**

Federal regulations require a description of how much information and what kind of information is to be disclosed.

Describe: _____

For the specific purpose of (describe in detail): _____

_____

This authorization will expire 180 days from the date of signing.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control. I understand I have the right to:

1. **Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.**
2. **Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.**
3. **Inspect a copy of Patient Health Information being used or disclosed under federal law.**
4. **Refuse to sign this authorization.**
5. **Receive a copy of this authorization.**
6. **Restrict what is disclosed with this authorization.**
7. **I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.**

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

_____

IF NOT PATIENT, PLEASE INDICATE RELATIONSHIP TO PATIENT