**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*** here _____, I authorize the release of the following records, if such records exist**:**

_____Laboratory report _____EKG

_____Pathology reports _____X-Ray

_____Operative report _____Other, please be specific:_____

_____

**Janene Martin, ND**
410.296.4005 Tel
410.296.4636 Fax

2345 York Rd., Suite 102
Timonium, MD 21093

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