Dunkirk Family Practice, PA
2025 Chaneyville Road, Suite 200
Owings, MD 20736

_____
Patient Name (Please Print)

_____
Date of Birth

PURPOSE OF THIS FORM

In order for Dunkirk Family Practice, P.A. to use or disclose Protected Health Information to someone other than you, you must complete this Authorization Form and return it to Dunkirk Family Practice, P.A.

Protected Health Information (PHI) is information that is created, received, transmitted or stored by Dunkirk Family Practice, P. A. which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, Dunkirk Family Practice, P. A. may not use or disclose PHI to persons other than those you specify on this form.

You may request that Dunkirk Family Practice, P. A. share information on your behalf by filling out this form. This form is not needed if you are requesting your own PHI. There is a separate Release Form for that type of request.

PART I: Authorized Person(s)
I authorize Dunkirk Family Practice, P. A. to disclose the PHI identified in Part II of this form to the following person(s): (Please designate at least one person and fill in their name and phone number)
( ) Spouse _____Phone# _____
( ) Parent _____Phone# _____
( ) Other (Please specify) _____Phone#_____

PART II: Description of the information to be used or disclosed
I authorize Dunkirk Family Practice, P.A. to disclose PHI (including written, electronic, or oral information) to the person identified in **PART** I of this form in connection with (mark all that apply): (If you want different people to have access to different information, you must fill out separate forms).
___All medical records, including consultations, labs, billing and/or account information
___All medical records pertaining to _____
___Lab reports only
___Immunizations only
___Other (Specify) _____

PART III: Validity of Form
___Dunkirk Family Practice, P.A. will provide a copy of this signed Authorization Form to me.
___This Authorization form is valid until the **earliest** of:
(1)_____ (please provide date or event);
(2)The date Dunkirk Family Practice, P.A. receives my written request for change; or
(3)Twenty years from the date I sign this form.

PART IV: Acknowledgement and Signature
I understand that:

- I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM.
- I HAVE THE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TO DUNKIRK FAMILY PRACTICE, P.A.
- CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE DUNKIRK FAMILY PRACTICE, P.A. RECEIVES THE CANCELLATION OF AUTHORIZATION FORM.
- THE PERSON I AM AUTHORIZING TO RECEIVE MY PHI MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL.

_____ _____
Your Signature (or Signature of Personal Representative*) Date

*If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.