



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) FROM MFM & GENETICS OF ADVANTIA

Section A: This section must be completed for ALL Authorizations					
Patient Name:		Birth Date:	Social Security No. (optional):		
Provider's Name and Address: MFM & Genetics of Advantia ATTN: Practice Manager 1443 U Street NW Washington, DC 20009 Phone : (771) 200-1920 Fax : (771) 200-1921		Practice Representative:			
		Address:			
		Phone:			
This authorization will expire on the following: (Fill in the Date or the Event, but not both.)					
Date:			Event:		
Purpose of Disclosure:					
DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in Medical Record <input type="checkbox"/> Registration Sheet <input type="checkbox"/> Medical History Form <input type="checkbox"/> Medication Sheet <input type="checkbox"/> Office Visit Notes <input type="checkbox"/> Nurse Notes		<input type="checkbox"/> X-Ray Films <input type="checkbox"/> Lab/Test Results <input type="checkbox"/> Operative Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Other Hospital Information <input type="checkbox"/> Physical Therapy Notes		<input type="checkbox"/> Notes from Other Providers <input type="checkbox"/> Disability/FMLA Forms <input type="checkbox"/> Work/School Notes <input type="checkbox"/> Itemized Bill <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
I understand that: 1. MFM & Genetics of Advantia Health will not condition treatment on my providing this authorization, except in the case of my participation in research related treatment. 2. I may refuse to sign this authorization and that it is strictly voluntary. 3. I may see and obtain a copy of the information described on this form, for a reasonable copy fee, by requesting it in writing. Under District of Columbia law this information will be provided to me within 15 days of my request. 4. I may revoke this authorization at any time by notifying MFM & Genetics of Advantia's Practice Manager, in writing, of my intent to do so. This will not affect any actions taken prior to receiving the revocation. 5. If the requester or receiver is not a health plan, health care clearing house, or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 6. I acknowledge that I have the right to a copy of this authorization after I have signed it.					
Section B: Is the Request of the PHI for the purpose of marketing? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, the health care provider must complete Section B, otherwise skip to Section C.					
MFM & Genetics of Advantia will <input type="checkbox"/> will not <input type="checkbox"/> receive financial or in-kind compensation in exchange for using or disclosing this information.					
Section C: Signatures					
I have read the above and authorize the disclosure of my Protected Health Information as described on this form.					
Signature of Patient or Patient's Representative:			Date:		
Relationship of Patient's Representative, if applicable:					
The authority of the patient's representative (attach <u>evidence</u> of authority to this Authorization):					