MFM & GENETICS
OF ADVANTIA

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

Section A: This section must be completed for ALL Authorizations

Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**
Name and Address of Referring Practice:	**Release to:** MFM & Genetics of Advantia ATTN: Practice Manager 1443 U Street NW Washington, DC 20009 Phone: (771) 200-1920 Fax : (771) 200-1921	

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

This request is NOT for psychotherapy notes. If it were, a separate authorization would be required for other items below. MFM & Genetics of Advantia may check as many items below as needed.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI in Medical Record ☐ Registration Sheet ☐ Medical History Form ☐ Medication Sheet ☐ Office Visit Notes ☐ Nurse Notes		☐ X-Ray Films ☐ Lab/Test Results ☐ Operative Reports ☐ Pathology Reports ☐ Other Hospital Information ☐ Physical Therapy Notes		☐ Notes from Other Providers ☐ Disability/FMLA Forms ☐ Work/School Notes ☐ Itemized Bill ☐ Other: ☐ Other:	

I understand that:

1. MFM & Genetics of Advantia 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: This Request for the PHI is NOT for the purpose of marketing.

MFM & Genetics of Advantia Health will ☐ will not ☐ 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 evidence of authority to this Authorization):