



Janene Martin, ND

410.296.4005 Tel
10.296.4636 Fax

6302 Falls Road
Suite C
Baltimore, MD 21209

**Authorization to Disclose Protected Health Information to
Dr. Janene Martin, ND
6302 Falls Road, Suite C, Baltimore, MD 21209**

Date _____
TODAY'S DATE

Patient's Name _____
FIRST MIDDLE LAST

Address _____
CITY STATE ZIP CODE

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:

Address _____
STREET ADDRESS / CITY / STATE / ZIP CODE

Phone _____
HOME WORK FAX

to disclose my Patient Health Information to: **Dr. Janene Martin, ND - (410) 296-4005**

PLEASE: **FAX** (410) 296-4636 - or - **MAIL TO:** 6302 Falls Road
Suite C
Baltimore, MD 21209

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

_____ Entire medical record _____ EKG
_____ Pathology reports _____ Laboratory report
_____ Operative report _____ X-Ray
_____ 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