



Janene Martin, ND

410.433.4005  
410.433.0909 fax

5801 Falls Road  
Baltimore, MD 21209

Authorization to Disclose Protected Health Information to Dr. Janene Martin, ND  
5801 Falls Road, 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) 433-4005**

PLEASE: **FAX** (410) 433-0909 - or - **MAIL TO:** 5801 Falls Road  
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 _____



Janene Martin, ND

503.961.2324  
503.536.6411 fax

5801 Falls Road  
Baltimore, MD 21209

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