J. Richard Lilly, M.D., A.B.F.P. and Associates

5804 Baltimore Ave.
Hyattsville, MD. 20781
(301) 927-7800
(301) 209-9474 (Fax)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name :_____ **DOB:**_____

Address:_____ **Social Security Number:** _____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

At the request of the individual, I _____, do hereby authorize J. Richard Lilly M.D. and Associates to release:
(Patient's name)

_____ ALL MEDICAL RECORDS _____ LAST 2 YEARS ONLY _____ OTHER (Explain)_____

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE:

_____Referral to specialist _____ Insurance _____ Workers Comp
_____Legal Investigation _____ Disability Determination _____ Personal
_____Other (Specify)_____

INFORMATION RELEASE TO: Name_____
Address_____
City_____ State_____ Zip Code_____

J. Richard Lilly, M.D. and Associates has contracted with **CIOX HEALTH** to process your request for medical records. The fee for this service is:

$0.36 per page/image for pages/images 1-200 $0.12 per page/image for pages/images 201+ *Plus first class postage
*** (E-delivery upon request same charges without postage charges)

You will receive an **invoice** from **CIOX HEALTH** for services rendered. Inquiries (1800-367-1500)

Please note that there is no fee for medical record requests sent directly to a physician or healthcare facility for continuing care purposes.

By signing below, I acknowledge that I am aware of the fee that will be billed to me for requesting a copy of my medical record. I agree to pay this fee when services are rendered and I receive an invoice from CIOX Technologies.

Note:Federal and state laws permit a fee to be charged for the copying of patient records

I hereby authorize disclosure of the health information for the above named patient. I authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of individual or guardian or personal representative of patient's estate **Date**

Updated: 06/24/16 **Intials**_____

Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

Requester Name			
	First	Last	
Street Address			
	Street	Suite / Apt #	
	City	State	Zip

Email Address for record delivery

Medical Records Requested			
Patient Name			
	First	MI	Last
Date of Birth			
Date of Service			
	From	To	

Please provide me with the medical records described above through the HealthPort eDelivery online service. I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on HealthPort's **eDelivery** website.
- I will receive an email from **HealthPort.com** containing instructions for accessing my records.
- If I do not retrieve my records within 30 days, they will be deleted.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Signature _____ Date**:** _____