MAXIM HEALTH SYSTEMS
AUTHORIZATION & REQUEST FOR RELEASE OF PHI

Section A. Scope of Authorization.

1. I, _____, hereby authorize and request Maxim Health Systems ("MHS"), located at 7227 Lee DeForest Road, Columbia MD 21046, to release the following information contained in the medical/financial record of _____ *(insert consumer's name)* to: _____ *(insert **name and address** of the person or entity authorized to receive the records)*

☐ Wellness Screening Consent Form/Results _____; or
(insert date and location of clinic)

☐ Immunization Consent Form _____; or
(insert date and location of clinic)

☐ Other _____
(identify specific information to be released, including dates; attach additional pages if necessary.)

2. The information will be used/disclosed for the following purpose: ☐ Personal ☐ Continuity Care
☐ Billing/Insurance Claims ☐ Litigation ☐ Other _____

3. MHS will not receive financial or in-kind compensation in exchange for use or disclosure of the information.

4. I understand that the medical record may include information concerning psychiatric diagnoses, drug abuse, alcoholism or communicable or venereal diseases (including, without limitation, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome [AIDS]). With this knowledge, I hereby give my consent to release the requested information from the above-referenced medical record, including any information concerning the patient's identity.

Section B. Patient's Rights. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. Further, I understand that I may inspect or copy any information used or disclosed under this authorization and that I may revoke this authorization in writing at any time by notifying MHS in writing, accept to the extent that action has been taken in release on this authorization before revocation.

Section C. Patient/Legal Representative Authorization. By my signature below, I authorize MHS and the above-named recipient to use, disclose or receive the information identified herein and understand that if the recipient that receives the information is not a health care provider or health plan covered by federal privacy regulations, this information described above my be redisclosed by the recipient and no longer protected by those regulations.

I hereby release MHS and its affiliates, officers, directors, employees, attorneys, agents, assigns, representatives and all persons authorized to act on its behalf, from all responsibility for loss of confidentiality by compliance with this authorization.

This authorization will expire on _____ (date) OR _____ (event).

_____ _____
Patient/Legal Representative Signature Date Witness Signature Date

NOTE: Pursuant to applicable laws governing a patient's right to privacy and confidentiality of medical records, any Power of Attorney, Legal Guardian or Estate Representative signing this Authorization on patient's behalf must provide copies of all appointment/governing documentation (e.g.: Durable Power of Attorney for Healthcare/Finances, Letters of Testamentary/Administration, Guardianship Orders, etc.) before the release of information.