MARYLAND AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR § 164.508 and the Annotated Code of Maryland, Title 10 Health General Article §§ 4-301 – 4-307. All items on this authorization must be completed in full, or the request will not be honored.
I hereby authorize **Med-Care Transportation (MCT LLC)** (hereinafter referred to as the "entity") to release the protected health information of:

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

PHONE #: _____

SOCIAL SECURITY NUMBER: _____

The information is to be released to:

NAME: _____

ADDRESS: _____

PHONE #: _____

FAX/E-MAIL: _____

The information I wish to have released is:

_____

_____

_____

☐ I do ☐ I do not wish to have information about HIV/AIDS released under this authorization.
☐ I do ☐ I do not wish to have mental health records released under this authorization.
☐ I do ☐ I do not wish to have information about drug/alcohol abuse released under this authorization.

If **MedCare Transportation (MCT LLC)** is in possession of records from another provider:
☐ I do ☐ I do not wish to have those records released under this authorization.

The purpose for such disclosure is:
☐ Payment / Insurance ☐ Healthcare
☐ Employment ☐ Other
☐ Per my request (only patient may check)

MedCare Transportation
1220 E. Joppa Rd
Building C, Suite 506
Towson, MD 21286

410-375-6915 Office
443-275-1094 Fax
www.medcaretransportation.com
mctinfo@medcaretransportation.com

This authorization will expire one year from the date signed, unless otherwise indicated here: ____/____/_____

I understand:

- This authorization is voluntary.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing of this authorization form.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke the authorization, I understand that I must notify MedCare Transportation (MCT LLC) in writing.

I understand that once information covered by this authorization has been disclosed, re-disclosure of the information by that recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by Maryland law.

_____ _____
Patient or Personal Representative's Signature Date

If the signature above is anybody other than the patient, explain your authority to act for the patient:

_____

_____

_____

_____

_____ _____
Witness Date

If there is a question or concern with responding to this authorization, you will be contacted by MedCare Transportation (MCT LLC) to discuss it. Questions or complaints about the federal privacy regulations or policies and procedures regulations should be directed to mctinfo@medcaretransportation.com or kanderson2@medcaretransportation.com or calling 410-375-6915 and speaking with a manager.