DAJA Health

AUTHORIZATION FOR THE RELEASE OF PRIVATE HEALTH INFORMATION

PLEASE COMPLETE ALL SECTIONS OF THIS FORM FOR THE RELEASE OF YOUR MEDICAL RECORDS. IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE FRONT DESK.

PATIENT'S NAME: _____DATE OF BIRTH: _____
ADDRESS: _____PHONE NUMBER: _____

I HEREBY REQUEST THAT DAJA HEALTH, LLC
6305 IVY LANE, SUITE 260
GREENBELT, MD 20770
PHONE: 301-552-3500 FAX: 866-207-0983

OR ANY SUCH PERSON AS THEY MAY AUTHORIZE, AND PERMIT THEM TO EXAMINE, COPY OR REPRODUCE IN ANY MATTER, ANY AND ALL PORTIONS DESIRED BY THEM OF THE FOLLOWING:
PLEASE INCLUDE PHI DATE RANGE TO BE RELEASED: _____
DESCRIPTION OF PHI TO BE RELEASED (CHECK ALL THAT APPLY):

__ENTIRE MEDICAL RECORD __CONSULTATION NOTES __LAB/EKG REPORTS __PRESCRIPTION RECORD
__RADIOLOGY REPORTS __BILLING RECORDS
___OTHERS (SPECIFY):_____

PLEASE SEND THE RECORDS LISTED ABOVE TO THE FOLLOWING:
__ **MYSELF** NAME OF PATIENT: _____
ADDRESS:_____

OR
__ **DOCTOR NAME/FACILITY NAME:** _____
ADDRESS:_____ PHONE NUMBER: _____FAX NUMBER: _____

THIS IS A PATIENT REQUEST; THE PATIENT WILL BE CHARGED FOR THE MEDICAL RECORDS UNLESS OTHERWISE NOTED; FEE: $0.99 PER PAGE (IF THE PATIENT IS REQUESTING) AND FULFILLMENT FEE (ACTUAL POSTAGE); THERE WILL BE A $35 ADMINISTRATION FEE FOR YOUR RECORDS TO BE TRANSFERRED TO ANOTHER PHYSICIAN.

I UNDERSTAND THAT THE MEDICAL PROVIDER TO WHOM THIS AUTHORIZATION IS FURNISHED MAY NOT CONDITION ITS TREATMENT OF ME ON WHETHER OR NOT I SIGN THE AUTHORIZATION. I UNDERSTAND I AM NOT REQUIRED TO SIGN THIS AUTHORIZATION AND THAT THIS CONTRACT MAY BE REVOKED IN WRITING AT ANY TIME, WITH THE EXCEPTION TO THE EXTENT THAT DISCLOSURE OF PHI HAS ALREADY OCCURRED BEFORE THE RECEIPT OF REVOCATION BY THE NAMED PROVIDER. TO INITIATE REVOCATION OF THIS AUTHORIZATION, A DIRECT WRITTEN CORRESPONDENCE MUST BE SENT TO THE HEALTH CARE PROVIDER ABOVE WITHIN 5- DAYS FROM THE REQUEST.
I CERTIFY THAT I HAVE READ, SIGNED, AND RECEIVED A COPY OF THIS AUTHORIZATION UPON MY REQUEST.
PATIENT'S SIGNATURE: _____ DATE: _____