



Laboratories Administration
Robert A. Myers, Ph.D., Director

Purpose: This form is used to confirm the direction of an individual to authorize Maryland Department of Health to update patient demographic information on an individual's health record.

Please type or print neatly; we are not able to process incomplete or illegible forms.
*Indicates mandatory fields

*SECTION A: IDENTITY OF AUTHORIZED** PATIENT/GUARDIAN REQUESTING UPDATE(S) TO DEMOGRAPHIC INFORMATION

**Pursuant to Health General Code Ann. §4-301, authorized individual is defined as a "person in interest" who is (1) an adult on whom a health care provider maintains a medical record, (2) a person authorized to consent to health care for an adult, or (3) a parent, guardian, custodian or representative of a minor.

PLEASE CHECK ONE:

- Patent (Adult)
Parent of Minor Child
Parent/Guardian authorized to consent to healthcare (Adult)
Patent (Minor Consent)
Guardian of Minor Child
OTHER

Last Name: First Name: MI:
Phone: (home) (work) (fax)
Street Address: Apt #:
City: State: Zip:

*SECTION B: CURRENT HEALTH RECORD'S DEMOGRAPHIC INFORMATION

Last Name: First Name: MI:
Date of Birth: Social Security Number:
Patient ID Number (if known): Sex: Female Male Transgender F to M Transgender M to F
Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White OTHER
Ethnicity: Hispanic or Latino Origin? Yes No
Street Address: Apt #:
City: State: Zip:
Phone: (home) (work)

*SECTION C: REQUESTED UPDATE(S) TO DEMOGRAPHIC INFORMATION ON HEALTH RECORD (ONLY COMPLETE THE FIELDS THAT NEED TO BE UPDATED)

Last Name: First Name: MI:
Date of Birth: Social Security Number:
Patient ID Number (if known): Sex: Female Male Transgender F to M Transgender M to F
Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White OTHER
Ethnicity: Hispanic or Latino Origin? Yes No
Street Address: Apt #:
City: State: Zip:
Phone: (home) (work)

***SECTION D: DISCLOSURE BEING AUTHORIZED**

1. Provide in writing a detailed description of the patient demographic information you are authorizing us to update on your health record: _____

2. Purpose of the update: _____

***SECTION E: SIGNATURE**

To the Individual – Please Read the Following:

I authorize update(s) to the patient demographic information on my health record as described in sections C and D above. I understand this authorization is voluntary.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

Individual Requestor Signature: _____ **Date:** _____

PLEASE NOTE:

If you are signing this form electronically, please use /s/ followed by your typed name or electronic signature.

Please return this form via fax to (443) 681-4501 or via email to mdlabs.recordsrequest@maryland.gov

The Laboratories Administration is prohibited from conditioning the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on the requirement that a person in interest sign the authorization.