Request to Update Patient Demographic Information Form

MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

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

Purpose: This form is used to confirm the direction of an individual to authorize MDH 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**

PLEASE CHECK ONE:

☐ Patient (Adult)
☐ Parent of Minor Child
☐ Parent/Guardian authorized to consent to healthcare (Adult)
☐ Patient (Minor Consent)
☐ Guardian of Minor Child
☐ OTHER _____

Last Name: _____ First Name: _____ MI: _____

Phone: (home) _____ (work) _____ (fax) _____
(Must be a secured fax machine)

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

The Laboratories Administration is prohibited form 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.

***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.*