Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

# Request to Update Patient Demographic Information Form

**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:**

☐ 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**: _____

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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.*