Request to Update Patient Demographic Information Form

Maryland
DEPARTMENT OF HEALTH

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**: _____

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.