

**Authorization for Release of Protected Health Information**

<b>Patient Information:</b>		
Patient Name	Birth Date	Social Security No.
Address		Telephone No. ( )
Email Address (must be provided if electronic copies are requested)		

**Release of Information:**

I hereby authorize:

- Greater Baltimore Medical Center
- Other facility name: \_\_\_\_\_

to release health information from the medical records of the above-named patient.

For the following purpose:

- At my request
- Insurance
- Continuance of Medical Care
- Legal
- Other: \_\_\_\_\_

To: \_\_\_\_\_

*Name/Address of person/organization to which disclosure is to be made*

For treatment dates: \_\_\_\_\_  Inpatient  Emergency Room  
 Outpatient Surgery  Clinic

<p><b>Type of Access Authorized:</b></p> <input type="checkbox"/> Paper copies <input type="checkbox"/> Electronic copies <small>(e-mail address must be provided)</small> <input type="checkbox"/> Inspection of the record	<input type="checkbox"/> <b>Continuing Care Information (Discharge Summary, History and Physical, Consultation, Operative Report, Diagnostic and Medical Tests, Pathology Report)</b> <input type="checkbox"/> <b>ER Record</b> <input type="checkbox"/> <b>Clinic Record</b> <input type="checkbox"/> <b>Other</b> _____
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**THIS IS A TWO SIDED FORM. THE PATIENT OR REPRESENTATIVE MUST SIGN ON THE BACK.**



This authorization will expire one year from the date signed below unless specific expiration event or condition is named here:

\_\_\_\_\_. The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this Authorization for Release of Confidential Health Information. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect the information to be used or disclosed, as provided in 45 CFR 164.524.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein described. I understand that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I acknowledge that the material authorized for release may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I understand that disclosure of health information to a party other than the one designated above is forbidden without additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this "Authorization for the Release of Confidential Information."

If electronic copies have been requested, I have provided a valid e-mail address, either my own or that of my designated recipient. My records will be provided as Adobe PDF files on HealthPort's eDelivery website. I will receive an e-mail from HealthPort.com containing instructions for accessing my records.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

If you are **NOT** the patient but are signing on behalf of the patient complete the following:

I, \_\_\_\_\_,

Confirm that I am the legally appointed representative for the patient and I have checked the box to indicate my relationship to the patient below:

- |   |  |
|---|--|
| <input type="checkbox"/> Parent with Parental Rights        | <input type="checkbox"/> Medical Power of Attorney                           |
| <input type="checkbox"/> Registered Kinship Care Relative   | <input type="checkbox"/> Power of Attorney with Right to See Medical Records |
| <input type="checkbox"/> Court Appointed Guardian           | <input type="checkbox"/> Surrogate Decision Maker                            |
| <input type="checkbox"/> Legally Appointed Healthcare Agent | <input type="checkbox"/> Court Appointed Personal Representative of Deceased |

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative's Signature

\_\_\_\_\_  
Address/Phone Number

**You must attach proof of your authority to act on behalf of the patient as checked above (other than parent).**

**Fees/charges will comply with all laws and regulations applicable to release of information.**

**PROHIBITION ON REDISCLOSURE:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.