

Authorization for Release of Protected Health Information to a Spokesperson

As stated in the Greater Baltimore Medical Center's (GBMC) Notice of Privacy Practices, "we may release health information about you to a family member, other relative, or any other person identified by you who is involved in your care with your permission."

By signing this authorization, I allow GBMC to tell the spokesperson(s) named below the following information:

- My x-ray, laboratory, test findings, diagnosis, prognosis, and treatment plan either in person or by telephone.

By signing this authorization, I understand the following:

- This applies to services being rendered to me by the GBMC physician practice named below:
_____.
- This authorization is voluntary.
- Once this information is released to the spokesperson(s), the released information may no longer be protected by the federal privacy regulations.
- The spokesperson(s), medical power of attorney, health care agent or other individual allowed by law will be the only person(s) who may obtain specific information about me.
- My spokesperson(s) does not have decision-making abilities unless he/she is able to do that as set forth in the law.
- This authorization will expire one year from the date signed below unless a specific expiration event or condition is named here: _____.
- I may withdraw this authorization at any time by notifying the GBMC Privacy Officer in writing. If I do withdraw the authorization, it will not have any effect on actions taken by GBMC prior to receiving the written request.
- My treatment will not be affected by me choosing to sign or not to sign this document.
- I may refuse to sign this authorization.

YOU WILL RECEIVE A COPY OF THIS FORM ONCE IT IS COMPLETED

Patient Name: _____ DOB: _____

Spokesperson Information: PRINT CLEARLY

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Signature of Patient or Patient's Representative

Date

Printed name of Patient's Representative

Relationship to Patient