GBMC HealthCare, Inc. – Release of Information
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Authorization for Release of Protected Health Information – Page 1 of 2

Patient Information:	
Patient Name	Birth Date
Address (include street, city, state and zip code)	Telephone No. ( )
Email Address (must be provided if electronic copies are requested)	

Release of Information:

I hereby authorize the provider indicated below to release the health information of the above-named patient.

- ☐ Greater Baltimore Medical Center
- ☐ Gilchrist Hospice Care (includes Hospice of Washington County and Franklin Hospice)
- ☐ GBMC Health Partners' Practice: _____

I hereby authorize GBMC HealthCare to obtain copies of the health information from the provider listed below:

From:_____

_____

Name/Address of person/organization to which information is to be obtained

For the following purpose:

- ☐ At my request
- ☐ Insurance/Payment Purposes
- ☐ Continuing Medical Care
- ☐ Legal Purposes
- ☐ Other: _____

To:_____

_____

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

Date(s) of Service to be Released: _____

Requested Method of Release:

- ☐ **Electronic Copy – Release to MyChart (GBMC preferred and fastest release) (treatment dates after 9/30/2016)**
- ☐ Electronic Copy – E-Mail
- ☐ Electronic Copy - CD (treatment dates after 9/30/2016)
- ☐ Paper

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

Specific Information to be Released:

☐ Continuing Care Information (Discharge Summary, History and Physical, Consultation, Operative Report, Diagnostic and Medical Tests, Pathology Report)
☐ Laboratory Results
☐ Radiology Images & Reports (available on CD only)
☐ Other_____

This authorization will expire one (1) year from the date signed below unless an earlier specific expiration event or condition is named here: _____.

This authorization covers only medical records for the dates specified above. I understand that I have the right to refuse to sign this Authorization for Release of Protected Health Information. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to receive treatment.

I, the undersigned, have read the above and authorize GBMC HealthCare, Inc. (GBMC) to disclose the health information identified herein. I understand that this authorization may be withdrawn by me at any time, except to the extent that action has been taken in reliance upon it.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 information released may include information about alcohol or drug abuse treatment, behavioral or mental health services, HIV or AIDS diagnosis or treatment, or reproductive health care, as defined in 45 CFR 160.103. I understand that the disclosure by GBMC of health information to a party other than the one designated above may require a separate authorization, unless such disclosure is permitted by law. 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 otherwise protected under state or federal confidentiality rules, including 42 CFR Part 2. GBMC is released and discharged of any liability, and the undersigned will hold the facility harmless, for complying with this *"Authorization for the Release of Protected Health Information."*

If electronic copies have been requested to be sent via e-mail, I have provided a valid e-mail address, either my own or that of my designated recipient. My records will be provided as an Adobe PDF. I will receive an e-mail from medicalrecordrequests@gbmc.org containing instructions for accessing my records.

_____ _____ _____
Date Time 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:

☐ Parent with Parental Rights
☐ Registered Kinship Care Relative
☐ Court Appointed Guardian
☐ Legally Appointed Healthcare Agent
☐ Medical Power of Attorney
☐ Power of Attorney with Right to See Medical Records
☐ Surrogate Decision Maker
☐ Court Appointed Personal Representative of Deceased

_____ _____ _____
Date Time 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).