GBMC – Health Information Management - Correspondence
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Authorization for Release of Protected Health Information

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:

☐ 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 ☐ Diagnostic Testing Results

Type of Access Authorized:

☐ Paper
☐ Electronic Copy - CD
(treatment dates after 9/30/16)
☐ Electronic Copy – E-Mail
(e-mail address required)
☐ MyChart
(treatment dates after 9/30/16)
☐ Record Review

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

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 I understand that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it.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 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 anAdobe PDF or tiff file on CIOX's Connect Patient website. I will receive an e-mail from NoReply@cioxhealth.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:

- ☐ 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 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.