

GBMC – 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:	
<input type="checkbox"/> Greater Baltimore Medical Center	
<input type="checkbox"/> Other facility name: _____	
to release health information from the medical records of the above-named patient.	
For the following purpose:	
<input type="checkbox"/> At my request	
<input type="checkbox"/> Insurance	
<input type="checkbox"/> Continuance of Medical Care	
<input type="checkbox"/> Legal	
<input type="checkbox"/> Other: _____	
To: _____	
_____ <i>Name/Address of person/organization to which disclosure is to be made</i>	
For treatment dates: _____	
Type of Access Authorized: <input type="checkbox"/> Paper <input type="checkbox"/> Electronic Copy - CD (treatment dates after 9/30/16) <input type="checkbox"/> Electronic Copy – E-Mail (e-mail address required) <input type="checkbox"/> MyChart (treatment dates after 9/30/16)	<input type="checkbox"/> Continuing Care Information (Discharge Summary, History and Physical, Consultation, Operative Report, Diagnostic and Medical Tests, Pathology Report) <input type="checkbox"/> ER Record <input type="checkbox"/> Laboratory Results <input type="checkbox"/> Radiology Images & Reports (available on CD only) <input type="checkbox"/> Other _____
THIS IS A TWO PAGE FORM. THE PATIENT OR REPRESENTATIVE MUST SIGN ON PAGE 2.	



Authorization for Release of Protected Health Information – Page 2 of 2

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 I understand that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it.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 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:

- | | |
|---|--|
| <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 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).

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