

**Frederick Regional Health System
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

Patient Name _____ **Medical Record #** _____
 (Please print clearly & list any previous names) (office use only)
Patient Address _____ **SSN** XXX-XX-_____
 (optional)
Date of Birth ___/___/____ **Phone (home)** _____ **(other)** _____

For security, records may not be disclosed via email.
 I authorize the use or disclosure of the above named individual's health information as described below:

Release Records FROM:	<input type="checkbox"/> _____ (facility name) Address _____ Phone _____ Fax _____														
Release Records TO:	<input type="checkbox"/> _____ (name of facility/organization/person) Address _____ Phone _____ Fax _____ <input type="checkbox"/> If records are being released to self, please check here if you want the envelope marked "Personal and Confidential" <input type="checkbox"/> paper copies <input type="checkbox"/> electronic copy (CD)														
Information To be Released or Reviewed	<p>The following information is to be released (check appropriate boxes):</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> History & Physical Exam</td> <td><input type="checkbox"/> EKG/ECHO reports</td> </tr> <tr> <td><input type="checkbox"/> Consultations</td> <td><input type="checkbox"/> Radiology reports (films obtained from Radiology)</td> </tr> <tr> <td><input type="checkbox"/> Emergency Dept. Record</td> <td><input type="checkbox"/> Outpatient Rehab (PT/OT/ST) summary</td> </tr> <tr> <td><input type="checkbox"/> Operative report</td> <td><input type="checkbox"/> Drug, Alcohol, or HIV</td> </tr> <tr> <td><input type="checkbox"/> Discharge Summary</td> <td><input type="checkbox"/> Psychiatric records</td> </tr> <tr> <td><input type="checkbox"/> Lab/Pathology reports</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other: please specify _____</td> <td></td> </tr> </table> _____ For the date(s) of treatment _____	<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> EKG/ECHO reports	<input type="checkbox"/> Consultations	<input type="checkbox"/> Radiology reports (films obtained from Radiology)	<input type="checkbox"/> Emergency Dept. Record	<input type="checkbox"/> Outpatient Rehab (PT/OT/ST) summary	<input type="checkbox"/> Operative report	<input type="checkbox"/> Drug, Alcohol, or HIV	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychiatric records	<input type="checkbox"/> Lab/Pathology reports		<input type="checkbox"/> Other: please specify _____	
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Purpose for Disclosure	<p>I would like this information released for the following purpose:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Continued care by another provider</td> <td><input type="checkbox"/> Personal use</td> </tr> <tr> <td><input type="checkbox"/> Insurance</td> <td><input type="checkbox"/> Legal</td> </tr> <tr> <td><input type="checkbox"/> Social Security Disability</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Continued care by another provider	<input type="checkbox"/> Personal use	<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal	<input type="checkbox"/> Social Security Disability		<input type="checkbox"/> Other _____							
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I have read and understood the following:

- Frederick Memorial Healthcare will release all records of treatment for mental health, chemical dependence, sickle cell anemia, genetic conditions and AIDS/HIV. If I do not want these to be released, I indicate here that I do not want records released regarding the following _____.
- If I change my mind, I may write to the facility that I have authorized to release my records. This will not apply to records that have already been released.
- This authorization expires one year after I sign it or sooner (specify here: _____) the time period noted here may exceed one year only in certain situations specified by law.
- There may be a fee for releasing these records which is in accordance with Maryland law.
- Once records are released, Frederick Memorial Healthcare System cannot prevent them from being released to a third party.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
- If I do not sign this form, I will still be treated, unless the treatment is part of a research project that requires this authorization.

Signature of patient _____ Date _____ Time _____ Authorized Representative _____ Date _____ Time _____

Print Name _____ **Relationship to Patient** _____
 (Parent, guardian, power of attorney, etc) (If authorized person is signing, please also print name)

ID checked/verified by HIM _____ **Reason patient is unable to sign** minor deceased other: _____