Frederick Health Hospital
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name _____ **Medical Record #** _____
(Please print clearly & list any previous names) (office use only)

Patient Address _____

Date of Birth ___/___/_____ **Phone (home)** _____

☐ Frederick Health Hospital
☐ Frederick Health Medical Group
☐ Both

For security, records may not be disclosed via email except by our copy service.

I authorize the use or disclosure of the above named individual's health information as described below:

Release Records **FROM:**	☐ _____ (facility name) Address _____ _____ Phone _____ Fax _____
Release Records **TO:**	☐ _____ (name of facility/organization/person) Address _ _____ _____ Phone _____ Fax _____ ☐ If records are being released to self, please check here if you want the envelope marked 'Personal and Confidential' ☐ paper copies ☐ electronic copy (CD) ☐ electronic (fax) ☐ electronic (email)
Information To be Released or Reviewed	The following information is to be released (check appropriate boxes): ☐ History & Physical Exam ☐ EKG/ECHO reports ☐ Consultations ☐ Radiology reports (films obtained from Radiology) ☐ Emergency Dept. Record ☐ Outpatient Rehab (PT/OT/ST) summary ☐ Operative report ☐ Drug, Alcohol, or HIV ☐ Discharge summary ☐ Psychiatric records ☐ Lab/Pathology reports ☐ Office Visits ☐ Full copy of record ☐ Other: please specify _ _____ _____ For the dates (s) of treatment _____
Purpose for Disclosure	I would like this information released for the following purpose: ☐ Continued care by another ☐ Personal use ☐ Insurance ☐ Legal ☐ Social Security Disability ☐ Other _____

I have read and understood the following:

- Frederick Health Hospital 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 Health Hospital cannot prevent them from being released to a third party.
- To be valid, this form must be filled out completely and signed. A copy 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

_____ Relationship to patient _____
Print Name (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: _____

_____
Witness Signature Date Time