Frederick Memorial Healthcare 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:**	☐ ______________________ (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)
Information To be Released or Reviewed	**The following information is to be released (check appropriate boxes):** ☐ History & Physical Exam ☐ Consultations ☐ Emergency Dept. Record ☐ Operative report ☐ Discharge Summary ☐ Lab/Pathology reports ☐ EKG/ECHO reports ☐ Radiology reports (films obtained from Radiology) ☐ Outpatient Rehab (PT/OT/ST) summary ☐ Drug, Alcohol, or HIV ☐ Psychiatric records ☐ Other: please specify ______________________ ☐ Entire record of treatment dates ______________ **For the date(s) of treatment** ______________________
Purpose for Disclosure	**I would like this information released for the following purpose:** ☐ Continued care by another provider ☐ Insurance ☐ Social Security Disability ☐ Personal use ☐ Legal ☐ Other ______________

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** **Authorized Representative** **Date**

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

____
Print Name

ID checked/verified by HIM ________

Reason patient is unable to sign ☐ minor ☐ deceased ☐ other: ______________

Witness Signature ______________________ **Date** ______________