MedStar Health

- ❑ MedStar Franklin Square Medical Center
- ❑ MedStar Georgetown University Hospital
- ❑ MedStar Good Samaritan Hospital
- ❑ MedStar Harbor Hospital
- ❑ MedStar Montgomery Medical Center
- ❑ MedStar National Rehabilitation Network
- ❑ MedStar Southern Maryland Hospital Center
- ❑ MedStar St. Mary's Hospital
- ❑ MedStar Union Memorial Hospital
- ❑ MedStar Washington Hospital Center
- ❑ MedStar Family Choice
- ❑ MedStar Ambulatory Services
- ❑ MedStar Visiting Nurse Association
- ❑ MedStar Institute for Innovation
- ❑ MedStar Health Research Institute
- ❑ MedStar Medical Group
- ❑ MedStar PromptCare
- ❑ MedStar Radiology Network

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the following information:
Patient Name:_____
Address:_____
Phone: _____
SSN: _____Date of Birth:_____/_____/_____
I authorize the custodian of records of: _____
or other person/entity (specifically describe) _____
to disclose/release the following information: (check all applicable)(Fees may be charged for processing this request.):

- ❑ All records
- ❑ Inpatient Medical Records
- ❑ Outpatient Medical Records
- ❑ X-Ray/Radiology Records
- ❑ Laboratory/Pathology records
- ❑ Billing Records
- ❑ Abstract/Summary
- ❑ Pharmacy/Prescription records
- ❑ Psychotherapy/Psychiatric Care Records [**Note:** If this authorization is for psychotherapy notes, it may not be combined with any other authorization (other than another authorization for psychotherapy notes.)]
- ❑ Other (describe specifically) _____

__Note:__ If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s):_____
❑ Please send the records listed above to (use additional sheets if necessary):

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

❑ Please send the records that I marked above through an electronic delivery option
Email Address: _____
The information may be used/disclosed for each of the following purposes:

- ❑ At my request (only the patient can check this box)
- ❑ For my health care
- ❑ For payment/insurance
- ❑ For legal purposes
- ❑ Other _____

This authorization shall expire no later than: ____/____/____ or upon the following event _____(whichever is sooner), and may not be valid for greater than one year from the date of signature for medical records.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative and Relationship Representative's authority to sign for patient, *(i.e. parent, guardian, power of attorney for healthcare, executor)*

You have the right to revoke this authorization, except to the extent the custodian of records has already executed it, by sending your written request to the custodian of records.

A copy of this signed authorization must be given to the individual