MedStar Health

General Medical Records Release
Patient Request to Access/Obtain Copy of Protected Health Information
Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

_____

Phone: _____

Date of Birth: _____/_____/_____ Medical Record Number: _____

☐ I **authorize** the custodian of records of MedStar Health Home Care to **disclose/release** the following information* (check all applicable):

- ☐ All records
- ☐ Laboratory records
- ☐ Billing records
- ☐ Medication profile
- ☐ Psychotherapy/psychiatric care notes**
- ☐ Other (describe specifically) _____

OR

☐ I request **access** to my medical records covering the dates _____ to _____ for my personal inspection. I request to be granted access on (Date) _____ at (Time) _____. By signing below, I authorize MedStar Health Home Care to mail a notification regarding the acceptance or denial of my request to the address listed above.

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

If this authorization is for psychotherapy notes, it may ***not* be combined with any other authorization (other than another authorization for psychotherapy notes). **DO NOT** use this form for mental health records releases from MedStar entities located in Washington, D.C. Use only the ***Mental Health Records Release and Specific Authorization for Use or Disclosure of Protected Health Information (District of Columbia)***

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if necessary):

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone _____

Fax: _____ Fax: _____

Email: _____ Email: _____

MedStar Health

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 employment 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 Maryland 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 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 relied on it, by sending your written request to the Privacy Liaison, MedStar Health Home Care, 5233 King Avenue, Suite 200, Rosedale, MD 21237.

PLEASE NOTE FOR ADDICTIONS AND MENTAL HEALTH PATIENT PROTECTED INFORMATION:

Confidentiality of records for patients in a drug abuse or alcohol treatment program are protected by Federal Confidentiality Rules (42 CFR Part 2).

To Recipients of Federally Protected Records:

If this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2), the Fe deral rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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