MedStar Health

- ❑ MedStar Ambulatory Services
- ❑ MedStar Family Choice
- ❑ MedStar Franklin Square Medical Center
- ❑ MedStar Georgetown University Hospital
- ❑ MedStar Good Samaritan Hospital
- ❑ MedStar Harbor Hospital
- ❑ MedStar Health Home Care
- ❑ MedStar Health Physical Therapy
- ❑ MedStar Health Research Institute
- ❑ MedStar Institute for Innovation
- ❑ MedStar Medical Group
- ❑ MedStar Montgomery Medical Center
- ❑ MedStar National Rehabilitation Hospital
- ❑ MedStar Radiology Network
- ❑ MedStar Southern Maryland Hospital Center
- ❑ MedStar St. Mary's Hospital
- ❑ MedStar Union Memorial Hospital
- ❑ MedStar Urgent Care
- ❑ MedStar Washington Hospital Center
- ❑ _____

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

Please complete the following information:

Patient Name: _____ Phone: _____

Address: _____ Date of Birth: _____

_____ MM / DD / YYYY

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: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

❑ Please send the records that I marked above through an electronic delivery option. Otherwise, they will be mailed in paper format.

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. MedStar Health does not condition treatment, payment, enrollment or eligibility for benefits on the signing of this form. 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 (MM / DD / YYYY)

_____ _____

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