MONOCACY HEALTH PARTNERS

Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____City: _____ State: _____ Zip: _____

E-Mail Address: _____ Phone: _____

I request that my medical records from:

Dr. (First Name) _____ (Last Name) _____ (Phone number) _____

Or other healthcare facility: _____be disclosed to:

Recipient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax (healthcare provider only): _____

I authorize the following to be released from my Monocacy Health Partners medical record:

☐ *Specific Date(s):* _____ *to* _____ or ☐ *Full copy of record.*

☐ Office Visits from _____
☐ Preventative Exams
☐ Surgery Consults
☐ Other: _____
☐ Immunizations
☐ Radiology Reports
☐ Laboratory Reports

Purpose for request: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

Disclosure Format: ☐ US Mail – paper ☐US Mail - Disc- ☐Fax (Healthcare provider only)

State and Federal Law protects the following information. If this information applies to you, please indicate if you would like this information released/obtained.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation will not apply to information that has already been disclosed in response to this authorization.
- This authorization will expire one year after I sign it, or sooner if specified (specify here) _____

I understand and agree to the Authorization terms.

_____ ___/___/___ _____ ____/____/____

(Signature of Patient) (Date) (Signature of Witness) (Date)

If you are signing as a Representative for the above patient, you will be asked to provide ID

Your name (please print): _____ relationship to the patient: _____

Your signature: _____ Date: _____/_____/_____