Frederick Regional Health 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 ☐ EKG/ECHO reports ☐ Consultations ☐ Radiology reports (films obtained from Radiology) ☐ Emergency Dept. Record ☐ Outpatient Rehab (PT/OT/ST) summary ☐ Operative report ☐ Drug, Alcohol, or HIV ☐ Discharge Summary ☐ Psychiatric records ☐ Lab/Pathology reports ☐ Other: please specify _____ _____ For the date(s) of treatment _____
Purpose for Disclosure	**I would like this information released for the following purpose:** ☐ Continued care by another provider ☐ Personal use ☐ Insurance ☐ Legal ☐ Social Security Disability ☐ 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 Time Authorized Representative Date Time

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

ID checked/verified by HIM _____ **Reason patient is unable to sign** ☐ minor ☐ deceased ☐ other: _____

MR.CONS451

FMH.451 (12/22/2014)

_____ _____ _____
Witness Signature Date Time