MONOCACY HEALTH PARTNERS

Authorization for Use and Disclosure of Health Information

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

Address: _____City: _____ State: _____ Zip: _____

E-Mail Address: _____ Phone: _____

I request that my protected health information (PHI) from:

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

Or other healthcare facility:

_____

Be disclosed to:

Recipient Name: _____

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

Phone: _____ Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical records:

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

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

Purpose for request:

☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care ☐ Other: _____

Disclosure Format

☐Patient Pick-Up ☐US Mail – paper ☐US Mail - CD ☐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.

Alcohol, Drug, or Substance Abuse Records	☐ Yes	☐ No	Dates: _____
HIV Testing and Results	☐ Yes	☐ No	Dates: _____
Mental Health Records	☐ Yes	☐ No	Dates: _____

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 must be made in writing and presented, mailed or faxed to the appropriate location listed above. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will **expire** on the following date/event/condition: _____
- If I fail to specify an expiration date, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization, unless the treatment is part of a research project that requires this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand and agree to the Authorization terms.

_____ _____/_____ _____ _____/_____

(Signature of Patient) (Date/Time) (Signature of Witness) (Date/Time)

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: _____/_____/_____ Time: _____

JB5/31/18