FAMILY HEALTHCARE OF HAGERSTOWN

Date of Request_____

AUTHORIZATION FOR RELEASE OF PATIENT IDENTIFIABLE HEALTH INFORMATION

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR 164.508 and the Annotated Code of Maryland, Title 10 Health General Article 4-301—4-307.

I hearby authorize Family Healthcare of Hagerstown to ____ release to ____obtain from:

_____

(Physician, Hospital, Attorney, Insurance Company, self, etc)

_____

(Address, City, State, Zip Code) (Phone Number)

The following health information from the medical records of:

_____ _____ _____

Patient Name Date of Birth Social Security Number

Specific Information to be disclosed:

□ Entire Record □ Other (specify) _____

□ Test Results (specify) _____ □ Limitations (specify) _____

□ Most Recent History & Physical, Discharge Summary, Operative Report(s), and Consultation(s)

□ Dental Record

This health information is needed for:

□ Personal Use □ Continuing Medical/Dental Care □ School □ Insurance

□ Legal Reasons □ Social Security/Disability □ Military □ Other _____

I do____ I do not ____ wish to have information about HIV/AIDS released under this authorization.

I do ____ I do not ____ wish to have mental health records released under this authorization.

I do ____ I do not ____ with to have information about drug/alcohol abuse treatment released under this authorization.

I also understand that the person giving authorization by a written and dated notice to Family Healthcare of Hagerstown may revoke this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization expires one year from the date of signature, unless I specify otherwise or revoke it.

I understand that I may be charged for copies of my health information.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

I understand authorizing the use or disclosure of the health information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of Parent/Executor/Legal Representative Date Signature of Patient Date

_____ _____

Witness Date Witness Date