MedStar Health

General Medical Records Release and Authorization for Use or Disclosure of protected Health information

Please read the form carefully and fill it out completely. If pre-payment is not requested, you will be billed for the cost of copying and actual postage in accordance with State law.

Please complete the following information: **Appointment with:**_____

Patient Name_____Date of Birth_____

Address_____

City_____ State/Zip_____Phone_____SSN: _____

I authorize the custodian of records of _____or other person/entity
Patient's name on this line
(specialty describe) to disclose/release the following information: (check all applicable):

☒ **Last 2 years** ☐ **Abstract/Summary** ☒ **Laboratory/Pathology Records**

☐ **Pharmacy/Prescription Records** ☒ **X-ray/Radiology Records** ☐ **Billing Records**

Other (describe specifically_____

*Note: If these 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.

PLEASE send the records listed above to (complete right side if we are requesting records from another practice):
MUST HAVE FULL ADDRESS

Name: MedStar Medical Group at Old Emmorton Road **Name:**_____

Address: 2227 Old Emmorton Road Suite 220 **Address:**_____

Phone/Fax Number:410-569-9040/ 844-569-0856 **Phone/Fax Number:**_____

The information may be used/disclosed for each of the following purposes:

☐ **At My Request (only the patient can check this box)** ☐ **For Employment Purposes**

☐ **For My Health Care** ☐ **For Payment/Insurance**

☐ **Other:**_____

This authorization shall expire no later than _____or upon the following event_____ (whichever is sooner), except this authorization shall automatically expire upon a minor's 18th birthday and may not be valid for greater than one year from the date of signature for Maryland medical records.

I understand that after 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 the authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. 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 Legal Representative_____ Date_____

Printed Name of Patient Representative_____

Representative's authority to sign for patient
(parent, guardian, power of attorney for healthcare, executor, etc)_____

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.