CalvertHealth

# Authorization for Release of Health Information

**PATIENT INFORMATION** (Please Print)

| First Name: | Middle Initial: | Last Name: | |
|---|---|---|---|
| Name at Time of Treatment (if different than above): | Date of Birth (MM/DD/YYY): | Phone: | |
| Street Address: | City: | State: | Zip: |

**WHAT RECORDS DO YOU WANT?** (Check appropriate boxes below)

Records from: ☐ CHMC Hospital ☐ CHMG - Provider/Practice Name: _____

Date(s) of Service: _____/_____/_____ through _____/_____/_____

☐ Complete Records ☐ Emergency Room Records ☐ History & Physical ☐ Operative/Procedural Report

☐ Discharge Summary ☐ Lab/Pathology Results ☐ Imaging Results ☐ Patient Acct (Billing) Records

☐ Other (Immunization Records, Medication Lists, Behavioral Health) Please specify: _____

**WHAT IS THE PURPOSE FOR THIS RELEASE OF INFORMATION?**

☐ Continuation of Care ☐ Disability Determination ☐ Legal Purposes ☐ Payment of Insurance Claim

☐ Applying for Insurance ☐ Other: Please specify: _____

**IN WHAT FORMAT WOULD YOU LIKE YOUR RECORDS?** ☐ Paper ☐ Electronic (CD)

**HOW WOULD YOU LIKE YOUR RECORDS DELIVERED?** ☐ In-Person Pick-up ☐ Mail ☐ Fax

**TO WHOM SHOULD YOUR RECORDS BE RELEASED?** ☐ **Self** ☐ **Personal Representative** ☐ **Physician/Provider** ***(indicated below)***

| Recipient Name: | Recipient Phone: |
|---|---|
| Recipient Mailing Address: | Recipient Fax: |

**I UNDERSTAND:**

- This authorization will expire twelve (12) months from the signed date, unless an earlier date is identified:_____.
- Released information may include records related to behavioral/mental health care, substance abuse treatment, HIV/AIDS and genetics.
- This authorization may be revoked, in writing only to CalvertHealth, at any time except to the extent that action has been taken prior to receipt of revocation.
- Once information covered by this authorization has been disclosed, re-disclosure of this information by the recipient is possible. I understand the information may no longer be protected by the federal regulations referenced above, but may be protected by Maryland law.
- I agree to pay any applicable fees for the processing of this request.

**PLEASE SIGN YOUR NAME BELOW:**

| Signature of Patient or Personal Representative | Relationship to Patient (Please Print) |
|---|---|
| Witness Signature | Date / Time |
| Patient Medical Record No.: | Patient Account No.: |

* A U C . R E L *

100 HOSPITAL ROAD, PRINCE FREDERICK, MD 20678
(P) 410-535-8275 ♦ 301-855-1012
(F) 410-414-4666 ♦ TDD 410-535-5630