Western Maryland Health System

AUTHORIZATION FOR DISCLOSURES OF HEALTH INFORMATION

Patient Name: _____DOB: _____MR_____

I hereby authorize Western Maryland Health System the use or disclosure of my individually identifiable health information as described below: Please release my information to the following persons/organizations:

NAME:_____

ADDRESS: _____

I also authorize disclosure of records from: _____

This disclosure is to be used for the following purposes (s): ___Patient Request ___Workers' Compensation

___Insurance Claim ___ Attorney Request ___Continued Care ___ Other/Specify: _____

Please release the following: Date of Service _____ to _____

Check all that apply: ***There may be a charge for release of medical records.**

	Outpatient Records		In Patient Records
	Emergency Department		Discharge Summary
	X-ray Reports		History & Physical
	Laboratory		Operative Report
	Outpatient Surgery		Test Results
	Clinic		Entire Record
	Other:		Other:
	Preliminary images/draft reports		Preliminary images/draft reports

This authorization is intended as a release from all legal liability that may arise from the disclosure of the information requested. This authorization must be dated subsequent to the information being requested and is valid for ONE YEAR from the date of signature or as otherwise specified. Please see our *Notice of Privacy Practices* for instructions as how to revoke this authorization. We will not condition treatment, payment, enrollment, or eligibility for benefits on the completion of this authorization. Also, please be aware that once we disclose this information, per your instructions, the information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability & Accountability Act of 1996. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ _____

Patient or Authorized Person Date

_____ _____

Witness Date/Time

For Facility Use Only:

Date Received: _____Date Information Released: _____By Whom: _____

Identity of Requestor Verified: ☐ Photo ID; ☐ LOA; ☐ POA; ☐ Other _____ Information Released by what means: ☐ Fax; ☐ Mail; ☐ Hand Carried by patient/representative; ☐ Other _____