



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.**

<input type="checkbox"/>	Outpatient Records	<input type="checkbox"/>	In Patient Records
<input type="checkbox"/>	Emergency Department	<input type="checkbox"/>	Discharge Summary
<input type="checkbox"/>	X-ray Reports	<input type="checkbox"/>	History & Physical
<input type="checkbox"/>	Laboratory	<input type="checkbox"/>	Operative Report
<input type="checkbox"/>	Outpatient Surgery	<input type="checkbox"/>	Test Results
<input type="checkbox"/>	Clinic	<input type="checkbox"/>	Entire Record
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Preliminary images/draft reports	<input type="checkbox"/>	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 _____