UNIVERSITY of MARYLAND
BALTIMORE WASHINGTON
HEART ASSOCIATES

Formerly Arundel Heart Associates
7845 Oakwood Rd. Suite 106
Glen Burnie MD, 21061
P:410-768-0919, 410-760-5100
F: 410-760-5932

Release of Information Authorization/Request

Patient Name (print):_____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Last 4-digits of SSN#: xxx-xx-_____ Primary Contact Number: _____

INFORMATION TO BE RELEASED FROM:
Provider Name / Organization: _____
Address: _____
Phone #: _____ Fax #: _____

SEND INFORMATION TO: □ Myself at the address above unless otherwise noted (fees may apply)
Provider Name / Organization: _____
Address: _____
Phone #: _____ Fax: _____

REASON FOR RELEASE OF INFORMATION:
□ personal use (fees may apply) □ continued medical care □ transfer of care □ legal/disability

FORMAT OF INFORMATION TO BE DISCLOSED:
□ pick up from office □ fax to # listed above □ mail via USPS

INFORMATION TO BE DISCLOSED: □ EKG □ Echo □ Carotid Doppler □ Stress Test
□ Cath report □ Bypass report □ Blood Work (CBC, CMP, Lipid) □ Cardiology Consult
□ Office Note w/ updated medication list □ discharge summary □ Other _____

I understand that the information in my health record may include information relating to sexual transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Only such records and/or information believed necessary for the purpose expressed above shall be released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this request, I must do so in writing and present my written revocation to the Health Information Management Coordinator. I understand that the revocation will not apply to information that has already been released in response to this request. This request will expire on _____. If I fail to specify an expiration date or event, this authorization will expire one year from the date it was signed and is only valid for information preceding this date. I understand that I may receive a copy of this form after I sign it and inspect and copy information to be used or disclosed. **I also understand there may be a charge for this information.**

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure treatment.

_____ _____ _____
Date: Signature of Patient / Representative: Relationship to Patient*
*If not signed by patient or parent of a minor, authorizing documentation is required.