5-Hole 1/4 1 3/8 c-to-c

Patient Name _____ Date of Birth: _____
Address _____ SS #: _____
_____ Phone: _____
Date of Service _____

I hereby authorize **(*Facility/Program*)** _____ to release my medical records to (*Complete name and address*): _____

_____

_____

I hereby authorize _____ my Designated Care Giver, as noted on the attached form, the permission to retrieve copies of my Medical Records.

Please release the ☐ **Entire Medical Record** ***OR*** the following information ***(Check all that apply)***:

| | | |
|---|---|---|
| ☐ History and Physical | ☐ Operative/Pathology Report | **Method of Release** |
| ☐ Consultation Report | ☐ Pathology Slides/Block | |
| ☐ X-ray/Imaging Report(s) | ☐ Lab Report(s) | ☐ Paper |
| ☐ X-ray/Imaging Film | ☐ Emergency Room Record | ☐ CD/DVD |
| ☐ Mammography (*Original, not copy)** | ☐ Discharge Summary | ☐ Flash Drive Provided |
| | ☐ Abstract or Summary | ☐ Secure Website _____ |
| ☐ Photo(s) | ☐ Other _____ | |

Your medical record may contain information that is afforded a higher level fo confidentiality by UM Capital Region Health. UM Capital Region Health will not release the information listed below unless you place your **INITIALS** next to the type of information you wish to be released.

| Initials | Type of Information to be Released |
|---|---|
| _____ | HIV/AIDS information released under this authorization. |
| _____ | Mental health information released under this authorization. |
| _____ | Drug/alcohol abuse treatment information released under this authorization. |
| _____ | Developmental disability treatment information released under this authorization. |

The purpose for release of the above information: ☐ Continued Care ☐ Insurance ☐ Legal
☐ At my request ***(Patient only)*** ☐ Other: _____

This authorization will expire within 1 year unless otherwise indicated. I understand that authorization is voluntary and may be revoked at any time in writing except to the extent that action has already been taken in reliance to this authorization. Subsequent re-disclosure or recopying of this information is not authorized without specific consent of the patient or authorized representative as provided in the Annotated Code of the State of Maryland, Article 4-302 (d).

I understand that I do not have to sign this authorization to ensure that I receive medical care.

| **Signature of Patient/Patient Representative** | **Date/Time** | **Witness** |
|---|---|---|

If signed by other than patient, state relationship: ☐ Parent ☐ Guardian ☐ Legal Representative
☐ Other: _____

**Appropriate identification is required at the time of the release.**

**UM Capitol Region Health discloses medical information in compliance with HIPAA regulations. Refer to the Notice of Privacy Practices for a complete description of how information about you may be used and disclosed and how you can get access to your medical information. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.**



**UNIVERSITY OF MARYLAND CAPITAL REGION HEALTH**