

University of Maryland Medical System
 HIM Department, Release of Information
 110 S. Paca Street 9th Floor
 Baltimore, Maryland 21201-1595
 410-328-5706 Fax: 410-328-0537 TDD: 410-328-9600
 UMMSrelease@umm.edu

REQUEST FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

 Patient Name (print) Address _____
 _____ XXX-XX-_____
 Date of Birth Last 4-digits of SS# Daytime Telephone Number _____

INFORMATION TO BE RELEASED/RECEIVED FROM:
 Check the UMMS Affiliate: UMMC UMMC Midtown UM SJMC UM BWMC UM CRMC UM HMH
 UM Rehab & Ortho Institute UM Shore Easton UM Shore Dorchester UM Shore Chestertown UM UCMC
 Other Provider Name/Organization: _____
 Address: _____
 Phone #: _____ Fax #: _____

SEND INFORMATION TO: Myself at the address above unless noted below. Affiliate name above _____
 Provider Name/Organization: _____
 Address: _____
 Phone #: _____ Fax #: _____

FORMAT OF INFORMATION TO BE DISCLOSED:
 _____ Paper _____ Electronic (CD/Thumb drive) _____ Email (pdf format) Address: _____
 _____ MyPortfolio (pdf format) **By signing below you acknowledge that the security of transmission is not guaranteed.**

INFORMATION TO BE DISCLOSED:

SERVICE TYPE	DATE FROM	DATE TO	SPECIFIC INFORMATION	SPECIAL REQUEST
_____ Inpatient	_____	_____	_____	<input type="checkbox"/> Radiology Images
_____ Outpatient	_____	_____	_____	<input type="checkbox"/> Itemized Bill
_____ Emergency	_____	_____	_____	
_____ Other	_____	_____	_____	

CHANGING STATUS: I understand the manner in which my clinical data is shared via the UMMS HIE participation, and I wish to change my status as denoted below:
 Please initial one: _____ Opt-Out; - OR - _____ Opt-In (if currently in an Opt-Out Status)

I understand that the information in my health record may include information relating to sexually 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. Furthermore, I understand that this information has been disclosed from records protected by federal law (42 C.F.R. Part 2). These records are prohibited from further disclosure without written patient consent unless otherwise mandated by law. 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 Department. 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 or Representative Relationship to Patient*
 *If not signed by patient or parent of a minor, authorizing documentation is required.

