Authorization for Use and Disclosure of Medical Information

PATIENT ID LABEL

Patient Name: ______________________ **Date of Birth:** ____________ **Phone #:** ____________

Contact Person (if other than patient): ______________________**Contact Phone #:** ____________

I authorize Luminis Health to release my medical records, as specified below:

Information to be released:

❑ Abstract (Patient Demographics, Discharge Summary, History & Physical, Operative/Procedure Note, Laboratory, Radiology, and Pathology)

❑ Discharge Summary

❑ ED Record

❑ EKG

❑ Laboratory Reports

❑ Operative Report

❑ Pathology Reports

❑ Procedure Report

❑ Radiology Reports

❑ Radiology Images

❑ Transfer Summary

❑ Other: ______________________

____

Please check box if release is to include:

❑ Reproductive Health

❑ Mental Health

For the date(s) of service from: ____________ to ____________

Purpose of Request:

❑ Personal Use

❑ Continuing Care

Action requested (check one):

❑ Provide a copy of my health information to me:

❑ Release my health information to:

Name: ______________________

Street address: ______________________ City: ______________________

State: ________ Zip code: ____________ Fax Number (we cannot call before faxing): ______________________

Delivery options:

❑ Mail (to address above)

❑ Fax (to number above)

❑ Hand Carry
(Patient will be contacted at telephone number listed above when records are ready for pick-up)

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PATIENT ID LABEL

Authorization for General Release of Information:

I understand that:

- I have the right to revoke this authorization at any time.
- If I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department.
- Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- This authorization is only valid for 12 months from the date of signature and will only be in effect for visits which have occurred prior to the authorization date
- Authorizing the disclosure of this health information is voluntary.
- I can refuse to sign this authorization and I need not sign this form in order to assure treatment.
- I may inspect or receive copies of the information to be used or disclosed, as provided in Code of Federal Regulations (45 CFR 164.524).
- 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.
- The medical information released may contain information related to the diagnosis or treatment for HIV testing, drug and alcohol, or a psychiatric condition.

For questions about disclosure of health information, contact Health Information Management at 443-481-4137.

Signature of Patient Only: ____________________________________ **Date:** ___________ **Time:** __________

If you are NOT the patient but are signing on behalf of the patient, please complete the following:

I, ____, **am the (check which applies):**

❑ Parent (Rights to medical records have not been restricted by court order)

❑ Court appointed guardian

❑ Legally appointed healthcare agent

❑ Surrogate decision maker

❑ Medical power of attorney

❑ Power of attorney with right to see medical records

❑ Court appointed personal representative of deceased

You MUST attach proof of your authority to act on behalf of the patient as checked above.

Representative's Signature: ___________________________________ **Date:** __________ **Time:** __________

Submit this completed and signed authorization form to Health Information Management by mail, fax, or in person to:

Anne Arundel Medical Center
Health Information Management
2001 Medical Parkway
North Tower, 1st Floor
Annapolis, MD 21401
Fax: 443-481-4111

or

Doctor's Community Medical Center
Health Information Management
8118 Good Luck Road
Lanham, MD 20706
Fax: 301-552-8018

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REV. 01/11/24