

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize Baltimore Washington Medical Center to use and disclose the protected health information (“PHI”) identified below:

concerning _____
(Patient’s Name)

Date of Birth: _____

Social Security # _____

Covering the period (s) of health care from: _____ **to** _____

to: _____
Recipient of PHI (name and address)

for the following purposes:

Pick up _____ Mail _____

Phone # _____

(Describe purpose – may include “at my request” if authorized by individual on whom PHI is kept)

Admission History/Physical

Radiology/EKG/Lab Reports

Consultation

Discharge Summary

Rehabilitation Evaluation

Outpatient Records

This authorization will expire on: _____
(Expiration date or event which may be no longer than 1 year)

I understand that I may revoke this authorization in writing at any time except to the extent that Baltimore Washington Medical Center or its employees or agents have acted upon this authorization. My written revocation must be submitted to the Privacy Officer, Baltimore Washington Medical Center.

I understand that if the organization authorized to receive the information is not a health plan or health care provider and if such information is re-disclosed by the recipient, the released information may no longer be protected by federal privacy regulations, but may be protected under Maryland law.

I understand that this authorization is voluntary. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

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 understand that there will be a charge for copying records.

Signature of Patient
or Patient’s Representative

If Patient’s Representative
Relationship to Patient

Date : _____

