SEIGEL, TULLY AND FURRER
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT TO COMAR 14.09.01.10 REQUIRING THE DISCLOSURE OF MEDICAL INFORMATION

TO: ____

(Name of Record Holder)

Patient/Claimant Name:	SSN:	Date of Birth:	D/A:

I, ________________________________, hereby, authorize you to give to: **Seigel, Tully & Furrer, LLC, 501 Fairmount Avenue, #100, Towson, MD 21286; (410) 669-9300:**

A copy of all information developed by you in my medical record while under your observation or treatment or otherwise in your possession including but not limited to:

Admission History & Physical	_______	Mental Health Records	_______
Operative Report	_______	Consultation Reports	_______
Pathology Report	_______	Radiology Reports	_______
Emergency Room Records	_______	Inpatient Records	_______
Outpatient Records	_______	Entire Record	_______
Drug or Alcohol Treatment Records	_______	Office Notes & Reports	_______
Police Reports	_______	Ambulance Reports	_______
Dental Records	_______	Invoices for Services	_______

(See notice below regarding Federal Law Confidentiality)

The purpose of the release of this information is at the patient's request.

This authorization is valid for up to one year from the date it is signed and may be revoked at any time in writing. I understand that this authorization can be used to release medical information including AIDS, ARC, HIV-Related diseases, DNA screening. Blood Alcohol Content, Alcohol/ Substance/Sexual/Domestic and Child Abuse, Adoption and/or Psychiatric Records. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

Disclosure of medical information pursuant to this authorization is ***NOT*** prohibited under the ***Health Insurance Portability and Accessibility Act ("HIPAA"). The Health Insurance Portability and Accessibility Act ("HIPAA")*** at 45CFR sec. 164.512 provides: "a covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation claims, automobile accident claims, or other similar programs, established by law that provide health benefits for injuries or illnesses without regard to fault. We will not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization.

____

SIGNATURE of claimant/patient or authorized representative

____

DATE

501 Fairmount Avenue, #100, Towson, MD 21286
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