



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION



10007

_____ Patient's Name	_____ Patient's Date of Birth
_____ Patient's Street Address	_____ Social Security Number
_____ City, State, Zip Code	_____ Phone Number

I, the undersigned, hereby authorize _____

to **release** copies of medical records to: to **obtain** copies of medical records from:

Verbal release only of medical information to:

_____ Name of Person or Agency	_____ Phone Number
_____ Address	_____ Fax Number
_____ City, State, Zip Code	

The purpose or need for such disclosure is _____

Dates of Service: _____

_____ is authorized to release the following: (Please check information to be released) The medical records to be released may contain medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, HIV / AIDS testing, HIV / AIDS results or HIV / AIDS information.

- | | |
|--|---|
| <input type="checkbox"/> Abstract (Summary, Op Report, Paths, Consults, H&P, lab work) | <input type="checkbox"/> Alcohol / Detox / Drug Abuse |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> X-ray, EKG, EEG, Labs, Cardiopulmonary |
| <input type="checkbox"/> Outpatient Surgery | <input type="checkbox"/> Physical Therapy / OT / Speech |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Nuclear Medicine |
| <input type="checkbox"/> Admission History and Physical | <input type="checkbox"/> Clinic |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Mental Health / Psychiatry |
| <input type="checkbox"/> HIV / AIDS Report | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Doctor's Office Notes | |
| <input type="checkbox"/> Operative Report / Pathology Report | |

_____ Signature	_____ Date	_____ Relationship to Patient
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_____ Witness	_____ Date
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This authorization will expire within 1 year unless otherwise indicated. The consent to disclose information may be revoked by me at any time in writing except to the extent that action has been taken in reliance thereon, as set forth in the LifeBridge Health Notice of Privacy Practices. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. 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) ***Photo Id may be requested at the time of release.**

_____ MR#	_____ Date Completed	_____ Completed By	_____ # pages
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