



Authorization for Use and Disclosure of Medical Information

Patient Name: _____ DOB: _____

Phone Number: () _____ Email Address (optional): _____

Contact Person (if other than patient): _____ Phone: () _____

I authorize the Anne Arundel Health System to release my medical records (including medical information related to the diagnosis or treatment for HIV testing, drug and alcohol, or a psychiatric condition) as specified below:

VISIT TYPE Emergency Room Inpatient Stay Outpatient Service

Service Date(s): _____

MEDICAL INFORMATION

- Complete Medical Record Xray Report Xray Films Pathology Reports
 Demographic / Visit History Lab History and Physical Exam Operative Reports
 Discharge / Transfer Summary EKG Consultation Reports Abstract
 Other: _____

REASON FOR REQUEST: _____

DELIVERY MODE

Patient / Designee to Hand-Carry. Please notify patient / contact at above phone number when photocopies are available for pick-up. May we leave a message to notify you when medical records are ready? Yes No
 Medical Records Handcarried On: _____ (date). Please Initial: _____

Mail photocopies to the following individual / organizations:

Name of Individual or Organization: _____

Street Address: _____

City, State, and Zip Code: _____

[Internal Use Only] Grant access to my complete medical record via AAHS Information Systems, to the following individual in accordance with applicable policies:

Name: _____ Relationship: _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise specified, this authorization will automatically expire in one year and will only be in effect for visits which have occurred prior to the authorization date unless otherwise specified.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be used or disclosed, as provided in CFR 164.524. I understand 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. For questions about disclosure of my health information, contact Health Information Management at 443-481-4123. **Please see www.aahs.org website for applicable fee schedule.**

Patient / Legal Representative Signature

Date

If you are not the patient, state legal relationship: _____
(Attach certifying documents)

Mail or fax completed form to:
Anne Arundel Medical Center
Health Information Management
2001 Medical Parkway
Annapolis, MD 21401
443-481-4111 (Fax)

COMPLETED ON
BY

