

MRN # _____

ACCT # _____

PATIENT ID LABEL

Authorization for Use and Disclosure of Medical Information

SECTION 1: DEMOGRAPHICS

PATIENT NAME (First, Middle, Last)	DATE OF BIRTH (MM, DD, YYYY)	PHONE # ()
CONTACT PERSON (if other than patient):		CONTACT 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:

SECTION 2: INFORMATION TO BE RELEASED (please complete left or right column)

Request for 5 or fewer visits are free of charge	Request for 6 or more visits a fee will be charged. Please call (443-481-4123) to verify charges
Purpose of Request: <input type="checkbox"/> Continuing Care <input type="checkbox"/> Personal Use	Purpose of Request: <input type="checkbox"/> Continuing Care <input type="checkbox"/> Personal Use
Service Date(s): _____	Service Date(s): _____
Visit Type: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency <input type="checkbox"/> Outpatient	Visit Type: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency <input type="checkbox"/> Outpatient
<input type="checkbox"/> Abstract (Patient Demographics, Discharge Summary, History & Physical, Operative / Procedure Note, Laboratory, Radiology, and Pathology) <input type="checkbox"/> ED Record <input type="checkbox"/> EKG <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Images (CD Copy) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Transfer Summary <input type="checkbox"/> Operative Report <input type="checkbox"/> Procedure Report <input type="checkbox"/> Other: _____ Format: <input type="checkbox"/> Electronic (CD) <input type="checkbox"/> Paper DELIVERY OPTIONS: <input type="checkbox"/> Mail to: Name: _____ Street: _____ City: _____ State: _____ Zip: _____ <input type="checkbox"/> Hand Carry (Patient will be contacted at telephone number listed in Demographics section when records are ready for pick-up) <input type="checkbox"/> Fax #: () _____ - _____ (Healthcare provider only)	<input type="checkbox"/> Abstract (Patient Demographics, Discharge Summary, History & Physical, Operative / Procedure Note, Laboratory, Radiology, and Pathology) <input type="checkbox"/> ED Record <input type="checkbox"/> EKG <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Images (CD Copy) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Transfer Summary <input type="checkbox"/> Operative Report <input type="checkbox"/> Procedure Report <input type="checkbox"/> Other: _____ <input type="checkbox"/> Complete Medical Record <input type="checkbox"/> NOT including nursing flow sheets <input type="checkbox"/> Including nursing flow sheets (For any number of visits a fee will be charged for complete records except for records sent to another healthcare provider.) DELIVERY OPTIONS: <input type="checkbox"/> Mail to: Name: _____ Street: _____ City: _____ State: _____ Zip: _____

[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: _____

SECTION 3: SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE

Authorization for General Release of Information

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 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 Code of Federal Regulations (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 health information, contact Health Information Management at 443-481-4123.

Signature of Patient / Legal Representative _____ Date / Time _____

If you are not the patient, state legal relationship _____

Mail or Fax Completed Form To:

Anne Arundel Medical Center
Health Information Management
2001 Medical Parkway
Annapolis, MD 21401
443-481-4111 (Fax)

