Ascension Saint Agnes

Authorization for Release of Protected Health Information

I authorize the following facility/physician_____ to release information from the record of:

Patient Name: _____

Date of Birth: _____ Medical Record# _____

Address: _____

Street City State Zip

Patient Phone Number: _____ Email:_____

As described below, the information will be released to:

Facility/Person to Receive Records: _____

Phone: _____ Fax: _____

Address: _____

Street City State Zip

I have been a patient at your facility, or I am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way. The facility cannot require me to sign the authorization in order to receive treatment.

Dates of Service for record request: FROM: ____/____/____ TO: ___/___/___

The following information or copies (place a check by types of records desired):

___Consultation Reports ___History & Physical Exam ___Physician Orders

___Discharge Summary ___Medication Administration Record ___Physician Progress Notes

___Laboratory Reports/Tests ___Psychiatric/Psychological Evaluation ___Operative Report

___EKG Report ___Rehabilitation Records ___Radiology Report

___Nurses Notes ___Pathology Report ___Entire Clinical Record

___Abstract (History & Physical, consults, labs, EKG's OR's, D/C Summaries, ER Reports)

___Billing or other business records (Specify): _____

___Other (Specify): _____

_____

HIV, mental health and drug/alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release:

___Drug/Alcohol ___HIV ___Mental Health (Psychiatric)

Reason for Request:

___Continuing treatment ___Employer ___Insurance ____Study/Research

___Legal ___Disability ___I do not wish to disclose the reason

____Self ___Other _____

This authorization will expire in six months or: _____

A disclosure state, as required by law, will accompany all records released. Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.

I realize there may be a charge for processing this record request. Please initial if you request to be notified in advance of any/all fees. Initial(_____)

If you do not initial, you will be billed for any associated fees with this request.

I understand that this authorization is subject to revocation at any time, except to the extent that Ascension Ministries has already acted in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth unless I revoke this authorization in writing and deliver request to the Privacy Officer. My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care, and I understand that I may be responsible for payment of the claim.

This information has been disclosed in accordance with Subtitle 3 of 4 of the Annotated Code of Maryland. Any individual or agency receiving this protected health information is prohibited from making further disclosure of this information, as provided by 4-303(b)(5)(ii). If this information contains patient information being admitted for treatment of alcohol or drug abuse, the confidentiality of this information is protected by Federal Law (Federal Regulation, 42 CRF Part 2) and prohibits further disclosure of this information expect with specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this use.

If I am physically unable to sign, I may provide oral authorization if witnessed by two (2) staff members.

**If authority to act is as Power of Attorney, supporting documentation must be included in this request. **

Patient or Authorized Representative Signature: _____Date: _____ _Time: _____

If representative, give relationship and authority to act: _____

If I am physically unable to sign, I may provide oral authorization if witnessed by two (2) staff members

Witness Signature: _____Date: _____Time: _____

Witness Signature _____Date: _____Time: _____

___Copy accepted ___Copy refused

All release of information requests must be sent directly to the corresponding facility or physician office. The physician's office should be contacted directly to obtain their fax number. A photostatic copy of this authorization shall be considered as valid and effective as the original. Please note that emails will be sent via a secure and encrypted electronic system.