

**Carroll Occupational Health**

700B Corporate Center Court; Suite A

Westminster, MD 21157

Phone: 410-871-0470 Fax: 410-871-0743

**Authorization to Release Medical Records**

SS#: \_\_\_\_\_

Patient Name: \_\_\_\_\_

I, \_\_\_\_\_ (your name) \_\_\_\_\_ (your telephone number) hereby authorize the entity named above to release the medical records of \_\_\_\_\_ (patient's name).

This may include information about serious communicable diseases and/or infections as defined by Maryland statute and Department of Public Health rules, which include Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), venereal disease and tuberculosis, if any; alcohol and/or drug abuse information protected under the regulations of 42 CFR Part 2, if any; psychiatric/psychological records, if any; social work records, if any; including communications made by me to a social worker, psychiatrist, or psychologist.

Name of individual or organization who will be receiving records:			
Address		Attention	
City	State	Zip	Phone No. Fax No.
Date(s) Treated at Clinic		Name Used at Time of Treatment	

**RECORDS TO BE RELEASED**

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Complete Medical Record
<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Physical Therapy Notes	<input type="checkbox"/> Xray Films	

**PURPOSE OF DISCLOSURE**

<input type="checkbox"/> Continuation of Care	Physician's Name:	<input type="checkbox"/> Insurance/Billing Verification	Company Name:
<input type="checkbox"/> Other (specify)			

**This authorization must be signed subsequent to the service date you are requesting and may be revoked at any time by notifying the entity named above in writing, except to the extent that action has already been taken based on this authorization. If not previously revoked, this authorization will terminate one (1) year from the date of signing. A photocopy or electrostatic copy will have the same authority as the original. Any redisclosure of medical information by the recipient(s) is strictly prohibited. I understand that if the entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.**

Signature <b>X</b>	Date	Signature of Witness <b>X</b>	Date
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I.D. Check

Relationship to Patient \_\_\_\_\_

(Note: If patient is unable to sign, the legal guardian or personal representative may sign. Proper court papers must be presented.)

**FOR PATIENTS REQUESTING XRAY FILMS**

Xray films are the property of the entity named above and requesting physicians are not authorized to keep them. If lost, original films cannot be replaced. When taking original films, patient acknowledges their responsibility to return the films within a reasonable period of time after completion of their appointment. Upon written request, the entity named above may permanently transfer original mammogram films.

For Internal Use

Information was: \_\_\_\_\_ Mailed On \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Initials: \_\_\_\_\_

\_\_\_\_\_ Picked up by \_\_\_\_\_ On \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Initials: \_\_\_\_\_