CorpOHS Frederick

490-L Prospect Blvd

Frederick, MD 21701

Phone: 240-566-3001 **Fax:** 240-566-3003

Authorization to Release Medical Records

SS#: ______________________ **Patient Name:** ____________________________________

I, ____ hereby authorize the entity named above
(your name) (your telephone number)
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

☐ History and Physical	☐ Progress Notes	☐ Complete Medical Record
☐ Lab Reports	☐ Radiology Reports	☐ Other (specify)
☐ Physical Therapy Notes	☐ Xray Films	____________________________________

PURPOSE OF DISCLOSURE

☐ Continuation of Care Physician's Name:	☐ Insurance/Billing Verification Company Name:
☐ 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	Date	Signature of Witness	Date
X		**X**	

☐ 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:* __________