MedStar Health

General Medical Records Release
Patient Request to Access/Obtain Copy of Protected Health Information
Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____
Address: _____
_____
Phone: _____
Date of Birth: _____/_____/_____ Medical Record Number: _____

☐ I request a **copy** of my medical records covering the dates _____ to _____. I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies, and postage (if applicable and as permitted by law). I authorize MedStar Health to mail my medical records to the address listed above.

OR

☐ I request **access** to my medical records covering the dates _____ to _____ for my personal inspection. I request to be granted access on (Date) _____ at (Time) _____. By signing below, I authorize MedStar Health to mail a notification regarding the acceptance or denial of my request to the address listed above.

OR

☐ I **authorize** the custodian of records of:_____ or other person/entity (specifically describe)_____to **disclose/release** the following information* (check all applicable):

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing records
- ☐ Abstract/Summary
- ☐ Pharmacy/prescription records
- ☐ Psychotherapy/psychiatric care notes**
- ☐ Verbal Release of PHI
- ☐ Other (describe specifically)_____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, mental health or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

If this authorization is for psychotherapy notes, it may ***not* be combined with any other authorization (other than another authorization for psychotherapy notes). **DO NOT** use this form for mental health records releases from MedStar entities located in Washington, D.C. Use only the ***Mental Health Records Release and Specific Authorization for Use or Disclosure of Protected Health Information (District of Columbia)***

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if necessary):

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Name: _____
Address: _____
_____
Phone _____
Fax: _____

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For my health care
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other: _____
_____

This authorization shall expire no later than: ___/___/___ or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature for Maryland medical records.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____	_____
Signature of patient (or patient's personal representative)	Date
_____	_____
Printed name of patient representative	Representative's authority to sign for patient, *(i.e. parent, guardian, power of attorney for healthcare, executor)*

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Liaison, enter facility name and address.

PLEASE NOTE FOR ADDICTIONS AND MENTAL HEALTH PATIENT PROTECTED INFORMATION:

Confidentiality of records for patients in a drug abuse or alcohol treatment program are protected by Federal Confidentiality Rules (42 CFR Part 2).

To Recipients of Federally Protected Records:

If this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2), the Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

A copy of this signed authorization must be given to the patient