CARDIOVASCULAR SPECIALISTS OF CENTRAL MARYLAND
A Community Specialty Practice of Johns Hopkins Medicine
10710 Charter Drive, Suite 400 • Columbia MD 21044
Medical Records: (443) 276-6070, Fax (443) 276-9636

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PLEASE READ THIS FORM CAREFULLY AND FILL IT OUT COMPLETELY.
Forms with missing information will be returned for completion before records can be released.

I authorize Cardiovascular Specialists of Central Maryland (CSCM), on behalf of itself and its medical providers, to release medical information to:

_____
NAME OF PERSON OR ORGANIZATION TO WHOM OR WHICH INFORMATION IS TO BE SENT

_____
STREET ADDRESS CITY STATE ZIP CODE

The following medical record report(s) for services PROVIDED or ORDERED by CSCM providers are to be released (check all applicable):

___ Most recent office visit or consult note
___ Most recent cardiac cath/angioplasty procedure note
___ Most recent electrocardiogram (EKG) report
___ Most recent cardiac stress test report
___ Most recent echo/stress echo report
___ Other (please be SPECIFIC) _____
___ Most recent hospital discharge summary
___ Most recent lab test (blood work) results
___ Most recent nuclear imaging study
___ Most recent holter/event monitor report

The following medical record reports for services <u>provided or ordered by other health care providers or facilities</u> are to be released if the reports are part of CSCM's medical record at the time of this request (describe specific records in detail):
_____
_____
This request applies to records from (date) _____ through (date) _____
PURPOSE OR NEED FOR DISCLOSURE (check applicable purpose):
___ Continued medical care ___ Payment of insurance claim ___ Legal ___ Personal use
___ Workers comp or disability claim ___ Other _____

I understand that this authorization shall expire in one year, and that I must sign a new authorization if I wish information released to a different person or organization and/or if I wish information to be released to the listed person or organization that has been created AFTER the date this authorization is signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken on this consent by CSCM. I also understand that CSCM has no control over the records once they are disclosed, and that there is the potential for the records to be re-disclosed by the recipient.

I understand that a reasonable fee may be charged for the duplication of records, in accordance with current state and/or Federal HIPAA regulations. An estimate of these charges will be provided, upon request, prior to duplication of records. The person or facility receiving these records may be provided with a copy of this authorization.

If this authorization pertains to alcohol or drug information, please note that this information has been disclosed 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 written consent of the person to whom 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.

_____ _____
PATIENT'S NAME (AT TIME OF TREATMENT) PATIENT'S DATE OF BIRTH

_____ _____
STREET ADDRESS LAST 4 DIGITS OF PATIENT'S SOCIAL SECURITY NUMBER

_____ _____
CITY STATE ZIP CODE DAYTIME PHONE NUMBER

_____ _____
SIGNATURE RELATIONISHIP TO PATIENT DATE

Notice to Recipient: This record has been disclosed in accordance with Subtitle 3 and 4 of Title 4 of the Health-General Article of the Annotated Code of Maryland.

Form revised February 2011