HOSPITAL

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, authorize and request Shady Grove Adventist Hospital to release copies of my medical records to:

NAME / INSTITUTION:	PHONE #:

ADDRESS:

The foregoing is subject to limitations as indicated below:

☐ 1. Confined to records regarding admission and treatment for following medical condition or injury:

_____

on or about _____ (date of service) at Shady Grove Adventist Hospital.

Type of Service: ☐ Inpatient ☐ Outpatient ☐ Emergency ☐ Same Day Surgery

☐ 2. Portion of chart to be released:

☐ Face Sheet	☐ Cardiology Report	☐ Review of Record
☐ History & Physical	☐ Emergency Room Records	☐ Lab Report
☐ Discharge Summary	☐ Consultation	☐ Path Report
☐ Operative Report	☐ Entire Record	☐ Physical Therapy
☐ Radiology Report	☐ Abstract	☐ Other (specify): _____

☐ 3. Correspondence files have not been researched in regards to prior release of this medical record. Please contact the Medicolegal Secretary at 301-279-6118 if you require any such correspondence.

☐ 4. Do these records contain documentation relevant to Psychiatric Information? _____

Alcohol Use * _____ Drug Use * _____

If yes, I hereby authorize disclosure for the following reasons: _____

_____

Records of this nature are protected under state and federal confidentiality laws and regulations. Shady Grove Adventist Hospital therefore requires the specific consent form in lieu of the general consent forms used by most requestors.

*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 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.

☐ 5. If the patient is a minor, incompetent, or unable to give consent, complete the following:
I further certify that the above mentioned patient is unable to give consent for reason(s) given below:

_____

and that I am authorized to consent for him/her (evidence of which is attached).
The hospital records released pursuant to this authorization may not be re-disclosed unless authorization for such redisclosure is obtained from the patient or otherwise permitted by Maryland Law.

This consent is subject to revocation at any time except to the extent that the Hospital has already taken action in reliance on it. If not previously revoked, this consent will terminate 90 days from the date you sign it.

Signature: _____ Date: _____

PATIENT ADDRESS:

PATIENT PHONE #:	MR #:	DATE OF BIRTH

RELATIONSHIP (IF NOT PATIENT)

WITNESSED BY:	TITLE:

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