

University of Maryland Medical Center
22 South Greene Street
Baltimore, Maryland 21201-1595
410-328-5706 Fax: 410-328-0537 TDD: 410-328-9600

Authorization for Release of Information

HEALTH INFORMATION MANAGEMENT SERVICES

HISTORY # _____

I hereby authorize University of Maryland Medical Center (UMMC) to **release/receive** my medical record information including dates, history of illness, diagnostic and therapeutic treatment. The medical records to be **released/received** may contain medical information pertaining to psychiatric, drug and/or alcohol and diagnosis and treatment.

Patient information:

_____	_____	_____
Last Name	First Name	Middle Initial
_____		_____
Address		Apt. #
_____	_____	_____
City	State	Zip Code
_____	_____	_____
Date of Birth	Social Security #	Telephone #

Please release records covering the time period for _____ to _____

Information to be released: () Complete Copy () Abstract () Other _____

Purpose of disclosure: () Continuum of Care () Insurance () Self () Other _____

**** Please note a fee may be charged for copies of the medical record. ****

Information to be released/sent to: _____

Is the information to be released from a facility other than UMMC? Yes No

If yes, name of the releasing facility: _____

Format of information to be disclosed: () Paper () Electronic **Select One:** ___ CD ___ Thumb drive ___ Email pdf

Email Address: _____ By signing below you acknowledge that the security of transmission is not guaranteed.

- I understand the Medical Center may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- In addition, I authorize disclosure of medical records received from other providers. (Note: the disclosures of records furnished by other providers may be prohibited by those providers.)
- I understand this authorization shall expire in one year from the date noted below and can be revoked in writing at any time as provided in the Medical Center's Notice of Information Privacy Practices. Such a revocation will not cover disclosures made previously in reliance on this authorization.
- The Medical Center, its employees, officers and medical staff are released from legal responsibility or liability for the release of the information in accordance with this authorization
- I understand that the person/company receiving this information may not be subject to laws on confidentiality of medical information and may re-disclose it.

Signed: _____ (Patient or Representative) _____ (Date)

If not signed by Patient; authority to act for minor or incompetent patient:

() Parent () Guardian () Power of Attorney () Closest Family Member consenting for patient's care

Witness: _____

