Capital Womens Care

Frederick OB/GYN Division

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION
PATIENT INFORMATION

Patient Name:_____ Account # _____

Social Security#_____ Birth Date _____/_____/_____

Daytime Telephone _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize _____(NAME OF OTHER PROVIDER RELEASING INFORMATION) to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from the above named provider, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from the above named provider. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

PROTECTED HEALTH INFORMATION TO BE RELEASED FROM :
Name of Medical Facility:_____
Phone Number:_____
Fax Number: _____

PROTECTED HEALTH INFORMATION TO BE RELEASED TO :
Capital Women's Care, Frederick OB/GYN Division
61 Thomas Johnson Drive, Frederick MD 21702
Phone: (301) 663-6171 Fax: (301)695-4469

Purpose or need for this information is:_____
TYPE OF INFORMATION TO BE RELEASED:
1. **GENERAL RELEASE**:
Type of Record
_____ Medical Records/Excluding Protected Records (This will be limited to 2 years of information including x-ray, lab reports unless otherwise stated.)
_____ Lab Results (specify)_____
_____ X-ray Reports (specify)_____
_____ Surgical records (specify) _____
_____ Other Records (specify) _____

2. **INFORMATION PROTECTED BY STATE/FEDERAL LAW:**
____ Drug Abuse Diagnosis/Treatment (specify) _____
____ Alcoholism Diagnosis/Treatment (specify) _____
____ Mental Health Diagnosis (specify) _____
____ Sexually Transmitted Disease (specify) _____
____ Diagnosis/ Treatment or Counseling (includes Aids/HIV) (specify) _____

I understand that I have the right to receive a copy of this authorization. I also understand this authorization is valid for 90 days only and may be revoked in writing at any time prior by notifying _____(Name of Entity Releasing Information) in writing. I understand I have the right to revoke the authorization at any time except to the extent that action has been taken in reliance thereon.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that I have read, signed and received a copy of this authorization upon my request. I understand I will be billed for copies of my medical records according to HIPPAA State of Maryland and Federal Law.

_____ X _____ _____
Date Signature of Patient/Legally Responsible Party Relationship to Patient

Employee Initials _____