Adventist HealthCare
Shady Grove Orthopaedics

Authorization to Release Protected Health Information

Please use this form when requesting a copy of your Medical Records to be sent to yourself or someone else

Patient Name: _____ DOB: _____ Medical Record Number: _____

Address: _____

Phone Number: _____

I, _____ hereby authorize Adventist HealthCare Shady Grove Orthopaedics (AMG) to release Protected Health Information pertaining to the care and treatment of the patient listed above. I authorize the disclosure of the following information from the Medical Record:

The persons or entity who are authorized to receive this information are:

Name: _____ Relationship to Patient: _____

Address: _____

Telephone: _____

The purpose for which this information may be disclosed (Check one):

- ☐ At the request of the individual listed above
- ☐ Other (specify purpose)
- ☐ Legal
- ☐ Insurance

I authorize Shady Grove Orthopaedics to disclose/release the following information to the persons listed above (Check all that apply & note the dates of treatment):

- ☐ Records specific to a Provider or Location seen (Specify) _____
- ☐ Entire medical record
- ☐ Limited to the following dates of treatment From: _____ To: _____
- ☐ Laboratory/Pathology reports
- ☐ Radiology reports (e.g., X-ray, CT, MRI)
- ☐ Radiology images (e.g., X-ray, CT, MRI)
- ☐ Billing information (e.g., billing statements, balance due)
- ☐ Other _____

(continued on back)

I give special permission to release any information regarding: (please check)

- ☐ Substance abuse
- ☐ HIV information
- ☐ Psychiatric/Mental Health information
- ☐ Psychological/Neuropsychological
- ☐ Psychotherapy

I, _____(print name), acknowledge the following statements:

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Unless revoked this authorization will expire on the following date, event or condition _____ . If I fail to specify an expiration date, this authorization will automatically expire one year from the date signed. I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164- 524. If I have a question about disclosure of my health information, I can contact the HIM Director or Chief Privacy Officer.

Information that has been disclosed to you may be protected by Federal Confidentiality regulations (42 CFR Part 2). Federal rules prohibit you from making 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 the regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal regulations restrict any use of the information to criminally investigate or prosecute any patient receiving alcohol or drug abuse treatment.

Patient Signature: _____ Date: _____

Legal Representative: _____

Shady Grove Orthopaedics will mail the requested Medical Record to the mailing address above.

Please return this completed authorization form and a copy of your photo ID by mail or fax to the Adventist HealthCare Shady Grove Orthopaedics HIM Department:

Shady Grove Medical Center Health Information Management Department
9901 Medical Center Drive
Rockville, MD 20850

Phone: 240-826-6119
Fax: 240-826-5330