AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

1. I AUTHORIZE:	**2. TO RELEASE TO:**
Union Hospital ______________________	______________________________________
Name of Person or Organization	Name of Person or Organization
106 Bow Street ______________________	__ ____________________________________
Street Address	Street Address
Elkton, MD 21921 ____________________	______________________________________
City, State, Zip Code	City, State, Zip Code
Phone Number: 410-398-4000 ___________	**Phone Number:** ________________________
Fax Number: 410-392-2770 _____________	**Fax Number:** ___________________________

3. INFORMATION TO BE RELEASED: (Check all applicable)

- ❑ Admission History and Physical
- ❑ Discharge Summary
- ❑ Operative Reports
- ❑ Pathology Reports
- ❑ Radiology Reports
- ❑ Laboratory Reports
- ❑ Progress Notes
- ❑ Nursing Notes
- ❑ Orders
- ❑ Consultations
- ❑ EKG
- ❑ EEG
- ❑ Physical Therapy
- ❑ Occupational Therapy
- ❑ Respiratory Therapy
- ❑ Emergency Department
- ❑ Outpatient Surgery
- ❑ Records from Other Hospitals
- ❑ Entire Record
- ❑ Other: ________________
- ❑ Other: ________________

SPECIAL AUTHORIZATION FOR DRUG/ ALCOHOL AND OR PSYCHIATRIC TREATMENT RECORDS:

❑ I specifically authorize the disclosure of information pertaining to drug /alcohol and or psychiatric treatment ________ (Initials)

4. RECORDS FROM THE TIME PERIOD(S): ___/___/___ TO ___/___/___ ; ___/___/___ TO ___/___/___

5. THE PURPOSE OF THIS DISCLOSURE IS:

- ❑ Continued Medical Care
- ❑ Personal
- ❑ Payment of Insurance Claim
- ❑ Workers' Compensation Claim
- ❑ Legal
- ❑ Other: ________________

6. DURATION OF AUTHORIZATION: Unless otherwise revoked, this authorization is valid until ___/___/___, or for a period of one year, whichever is less.

7. **By signing below, I understand and acknowledge the following:**

- That I may revoke this authorization at any time by presenting a written revocation to the Director of Medical Records for Union Hospital.
- That I do not have the right to revoke this authorization if it was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or the policy itself.
- That any revocation will not apply to information that already has been released in response to this authorization.
- That information released pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.
- That Union Hospital will not condition treatment on my signing this authorization unless (1) I am enrolled in a research study and the treatment is part of that study, or (2) the sole purpose for the provision of health care is to disclose health information to someone else.
- That the fees for copying and mailing the information have been explained to me and I understand that I will be responsible for the costs of copying and mailing.
- That if I have any questions about disclosure of my protected health information, I may contact the Medical Records Department.

______________________________	______________________________
Patient's Name (at time of treatment)	Patient's Social Security Number
______________________________	______________________________
Street Address	Patient's Date of Birth
______________________________	______________________________
City, State, Zip Code	Daytime Phone Number
______________________________	______________________________
Patient's or Representative's Signature	Date
______________________________	______________________________
Printed name of patient's representative (if applicable)	Basis of the representative's authority (if applicable)