DOCTORS COMMUNITY HOSPITAL

8118 Good Luck Road
Lanham, MD 20706

Medical Records: 301-552-8073
Radiology: 301-552-8513
roirequest@dchweb.org

Authorization For Release of Medical Information

****There is a charge for a personal copy or the permanent transfer of your records. Ciox Health has been contracted to provide this service and will invoice you directly. Maryland State Rates apply plus first class postage. Records will be mailed upon receipt of payment.****

REQUESTS FOR OVER 25 PAGES ARE PRINTED OFF SITE AND MAY TAKE UP TO 14 DAYS TO PROCESS

Print Patient's Full Name: _____ Birth Date *(mo/day/yr)* _____

Street Address: _____ Social Security #: _____

City, State, Zip Code: _____ Home Phone: _____

At the request of the individual, I *(patient name)* _____ , do hereby authorize Doctor's Community Hospital to release:

Dates of Service: _____

❑ Discharge Summary	❑ Pathology Reports	❑ Emergency Reports	❑ Radiology Reports	❑ Other: _____
❑ Laboratory Reports	❑ X-Ray Films	❑ Progress Notes	❑ All Records	
❑ Operative Notes	❑ ECG / EEG / Cardiac Cath	❑ History & Physical	❑ Abstract	

Staff Comment _____ Initials _____ Date _____

❑ **I do** ❑ **I do NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

REQUEST COPY BE PROVIDED: ❑ On paper ❑ Electronically on CD

❑ By Email to this Email address: _____

INFORMATION RELEASE TO: _____
Name of Company / Agency / Facility / Person

_____
Street Address

_____
City, State, Zip

PURPOSE OF DISCLOSURE:

❑ Referral to Specialist	❑ Insurance	❑ Workers Comp	❑ Change of Doctor
❑ Legal Investigation	❑ Disability Determination	❑ Personal	❑ Continuing Care

❑ Other (specify) _____

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is given, may not condition my treatment based on this authorization.

Signature of Individual or Guardian or
Personal Representative of Patient's Estate _____ Date _____

❑ ID Checked _____

ORIGINAL - DCH CHART COPY (HIS) COPY 2 - DEPARTMENT COPY 3 - PATIENT