



Authorization for Use and Disclosure of Medical Information

PATIENT ID LABEL

Patient Name: _____ Date of Birth: _____ Phone #: _____

Contact Person (if other than patient): _____ Contact Phone #: _____

I authorize Luminis Health to release my medical records, as specified below:

Please check which facility you are requesting records from

☐ Anne Arundel Medical Center ☐ Doctor's Community Medical Center

☐ Luminis Health Clinical Enterprises (Please indicate below the practice you are requesting records from)

Information to be released:

☐ Abstract (Patient Demographics, Discharge Summary, History & Physical, Operative/Procedure Note, Laboratory, Radiology, and Pathology)

☐ Discharge Summary

☐ Operative Report

☐ Radiology Images

☐ ED Record

☐ Pathology Reports

☐ Transfer Summary

☐ EKG

☐ Procedure Report

☐ Other: _____

☐ Laboratory Reports

☐ Radiology Reports

☐ Progress Notes

Please check box if release is to include:

☐ Reproductive Health

☐ Mental Health

For the date(s) of service from: _____ to _____

Purpose of Request:

☐ Personal Use

☐ Continuing Care

Action requested (check one):

☐ Provide a copy of my health information to me:

☐ Release my health information to:

Name: _____

Street address: _____ City: _____

State: _____ Zip code: _____ Fax Number (we cannot call before faxing): _____

Delivery options:

☐ Mail (to address above)

☐ Fax (to number above)

☐ Hand Carry

(Patient will be contacted at telephone number listed above when records are ready for pick-up)



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Authorization for General Release of Information:

I understand that:

- I have the right to revoke this authorization at any time.
- If I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department.
- Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- This authorization is only valid for 12 months from the date of signature and will only be in effect for visits which have occurred prior to the authorization date
- Authorizing the disclosure of this health information is voluntary.
- I can refuse to sign this authorization and I need not sign this form in order to assure treatment.
- I may inspect or receive copies of the information to be used or disclosed, as provided in Code of Federal Regulations (45 CFR 164.524).
- Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- The medical information released may contain information related to the diagnosis or treatment for HIV testing, drug and alcohol, or a psychiatric condition.

For questions about disclosure of health information, contact Health Information Management at 443-481-4137.

Signature of Patient Only: _____ **Date:** _____ **Time:** _____

If you are NOT the patient but are signing on behalf of the patient, please complete the following:

I, _____, am the (check which applies):

- | | |
|---|--|
| ☐ Parent (Rights to medical records have not been restricted by court order) | |
| ☐ Court appointed guardian | ☐ Medical power of attorney |
| ☐ Legally appointed healthcare agent | ☐ Power of attorney with right to see medical records |
| ☐ Surrogate decision maker | ☐ Court appointed personal representative of deceased |

You MUST attach proof of your authority to act on behalf of the patient as checked above.

Representative's Signature: _____ **Date:** _____ **Time:** _____

Submit this completed and signed authorization form to Health Information Management by mail, fax, or in person to:

Anne Arundel Medical Center
Health Information Management
2001 Medical Parkway
North Tower, 1st Floor
Annapolis, MD 21401
Fax: 443-481-4111

or

Doctor's Community Medical Center
Health Information Management
8118 Good Luck Road
Lanham, MD 20706
Fax: 301-552-8018



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