



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): _____

Email Address: _____

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)
- Email (to the address above)



8 5 2 1 4



Authorization for Use and Disclosure of Medical Information

PATIENT ID LABEL

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
- Legally appointed healthcare agent
- Surrogate decision maker
- Medical power of attorney
- Power of attorney with right to see medical records
- 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



8 5 2 1 4