Authorization to Release Medical Information

INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION BEFORE RECORDS CAN BE RELEASED.

I authorize Cardiovascular Specialists of Central Maryland, P.A., on behalf of itself and its medical providers, to release medical information to:

____
NAME OF PERSON OR ORGANIZATION TO WHOM OR WHICH INFORMATION IS TO BE SENT

____
STREET ADDRESS | CITY | STATE | ZIP CODE

The following medical record report(s) for services PROVIDED or ORDERED by Cardiovascular Specialists providers is(are) to be released (check all applicable):

- ☐ Most recent office visit or consult note
- ☐ Most recent cardiac cath/angioplasty procedure note
- ☐ Most recent electrocardiogram (EKG) report
- ☐ Most recent cardiac stress test report
- ☐ Most recent echo/stress echo report
- ☐ Most recent hospital discharge summary
- ☐ Most recent operative report
- ☐ Most recent lab test (blood work) results
- ☐ Most recent nuclear imaging study
- ☐ Most recent holter/event monitor report
- ☐ Other [please be SPECIFIC] ______________________________

The following medical record report(s) for services provided or ordered by other health care providers and/or facilities is(are) to be released if the report(s) is(are) part of Cardiovascular Specialists' medical record at the time of this request (describe specific record(s) in detail):

____
____
____

This request applies to records from (date) ____/____/____ through (date) ____/____/____

PURPOSE OR NEED FOR DISCLOSURE (CHECK APPLICABLE PURPOSE):

- ☐ Continued medical care
- ☐ Payment of insurance claim
- ☐ Workers compensation or disability claim
- ☐ Legal
- ☐ Personal use
- ☐ Other ______________

I understand that this authorization shall expire in **one year**, and that I must sign a new authorization if I wish information released to a different person or organization and/or if I wish information released to the listed person or organization that has been created AFTER the date this authorization is signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken on this consent by Cardiovascular Specialists. **I also understand that Cardiovascular Specialists has no control over the records once they are disclosed, and that there is the potential for the records to be redisclosed by the recipient.**

I understand that a reasonable fee may be charged for the duplication of records, in accordance with current state and/or federal HIPAA regulations. An estimate of those charges will be provided, upon request, prior to duplication of records. The person or facility receiving these records may be provided with a copy of this authorization.

If this authorization pertains to alcohol or drug information, please note that this information has been disclosed from records protected by federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

______________________ ______________________
PATIENT'S NAME (AT TIME OF TREATMENT) | PATIENT'S DATE OF BIRTH

______________________ ______________________
STREET ADDRESS | LAST 4 DIGITS OF PATIENT'S SOCIAL SECURITY NUMBER

______________________ ______________________
CITY | STATE | ZIP | DAYTIME PHONE NUMBER

______________________ ______________________
SIGNATURE | **RELATIONSHIP TO PATIENT** | **DATE**

Notice to Recipient: This record has been disclosed in accordance with Subtitle 3 and 4 of Title 4 of the Health-General Article of the Annotated Code of Maryland.

Revised August 2009