ATLANTIC GENERAL HOSPITAL
care.givers

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS:

Please select location(s): ◯ **AGH** (Atlantic General Hospital) ◯ **AGHS** (Atlantic General Health System)
◯ **AHC** (Atlantic Health Center) ◯ **OTHER** (Specify) _____

PATIENT'S NAME: _____ **DATE OF BIRTH**: _____/_____/_____

SOCIAL SECURITY #: (optional): _____ CONTACT NUMBER: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

For this authorization my "Health Information" is: (charges may apply)

_____ Complete Record (ALL)
_____ **Include** information from other providers/facilities
_____ Admission History & Physical
_____ Discharge Summary
_____ Outpatient Record
_____ Emergency Room Record
_____ Diagnostic Test/Results Reports (lab, ex-rays and other test results)
_____ Digital Images (CD)
_____ Operative Report
_____ Abstract Record (Discharge, Summary, History & Physical, Operative Notes and Test Results)
_____ Pathology Report
_____ Other: _____

****Please initial below if release is to include:**
_____ Drug & Alcohol Records
_____ Mental Health Records
_____ Other: _____

****Date of Service Requested:** _____/_____/_____ **TO** _____/_____/_____

I authorize _____ to disclose/release my Health Information by:
(select one option): ◯ Mail ◯ Email ◯ Pick up

Medical Records going to:

PERSON OR ENTITY: _____
ADDRESS: _____
CITY: _____STATE: _____ZIP: _____
PHONE: _____ FAX: _____
EMAIL: _____

For the purpose(s) of: _____.

I understand **there may be a charge for copying and handling of my request**. I understand that all fees will be in compliance with applicable Maryland State guidelines. By signing this authorization, I agree to pay these fees at the time this request is made. This authorization is valid for one year from the date signed, unless I revoke this authorization. Atlantic General Hospital/Health System may contact me to extend this authorization, but I do not have to do so. **Atlantic General Hospital will ask me for photo identification upon my request for my medical records**. Atlantic General Hospital/Health System's medical staff and associates are pledged to maintain strict patient confidentiality in keeping with high ethical standards and in accordance with state and federal law. Atlantic General Hospital/Health System has procedure in place to support this policy. These procedures make it very unlikely that my health information will be improperly re-disclosed. However, if this happens, my health information may no longer be covered by these privacy protections. I am not required to sign this authorization. Atlantic General Hospital/Health System does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. I may request a copy of this authorization upon signature. I may revoke this authorization at any time in writing by using the guidelines on the back of this form.

►**PATIENT SIGN HERE:** PATIENT SIGNATURE: _____DATE: _____

I _____ represent that I am the healthcare Agent/Guardian/Power of Attorney/Parent of the patient named above. (For Healthcare Agents, Guardians or Power of Attorney, *attach verifying documentation*.)

►**PERSONAL REPRESENTATIVE SIGN HERE:** Personal Representatives' Signature: _____DATE: _____

ADDRESS: _____ PHONE: _____

CITY: _____STATE: _____ZIP: _____

By signing this authorization, I understand that medical records release may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

Notice to the recipient of these records: If the information concerns a person treated for alcohol or drug abuse, the confidentiality of this information is protected by federal law (Federal Regulation 42 CFR part 2) and prohibits further disclosure of this information except with specific written authorization of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose.

To revoke this authorization, I must mail or fax my written request along with a copy of this original authorization to:

Atlantic General Hospital
ATTN: Medical Records
9733 Healthway Drive
Berlin, Maryland 21811
Phone: (410) 641-9614 or (410) 641-9616
Fax: (410) 641-3410

If I am unable to provide a copy of this original authorization with my request, I will provide the following information:

- Date of Authorization
- Name
- Address
- Phone Number
- Social Security Number
- Date of Birth
- Purpose of Authorization
- Description of Requested Health Information
- Person/Entity authorized to Use/Receive the Health Information.

If this original authorization was signed by my personal representative, the request to revoke will also include:

- My Personal Representative's Name
- Relationship
- Address
- Phone Number

I understand that if I am unable to provide all of the above information, Atlantic General Hospital may not be able to honor my revocation request. I further understand that Atlantic General Hospital is unable to recall any of my Health Information that was released prior to my revocation of this authorization