Release of Imaging Records from Atlantic General Hospital

Patient Name:_____ Date of Request:_____

Date of Birth:_____ Phone Number:_____

I hereby authorize Atlantic General Hospital to release the following medical records (select all that apply):
☐ Mammogram (last two years) ☐ CD ☐ Film (surgeons only) ☐ Ultrasound (CD only) ☐ Bone Density

☐ Permanent transfer ☐ Temporary transfer
Reason: ☐ Moving ☐ Surgical Appt ☐ Exam Elsewhere ☐ Insurance ☐ Other_____

☐ Send images to the following address:

Facility Name: _____

Street Address: _____ Phone: _____

City, State, Zip: _____ Fax: _____

☐ Patient will pick up on:_____ (Please allow 48 hours for us to prepare you exams.) A photo ID will be required when picking up any exams.

If the patient sends someone else to pick up the exams, they must have a signed authorization from the patient before we can release them. Please complete:

☐ Patient Designee as noted below
I _____(patient name), grant access to pick up the medical records documented on this form to _____(name and relationship to patient).

Signature of patient: _____ Date:_____

I understand **there may be a charge for copying and handling 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 date signed, unless I revoke this authorization. Atlantic General Hospital may contact me to extend this authorization, but I do not have to do so. Atlantic General Hospital'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 has procedures 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 does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. I will receive a copy of this authorization upon signature. I may revoke this authorization at any time in writing by following the guidelines at the bottom of this form.

Signature of patient: _____**Date**:_____

I_____ represent that I am the healthcare agent/guardian/power of attorney/parent of the patient named above. (For healthcare agents guardian or power of attorney, attach verifying documentation)

_____ _____
Personal Representative's Signature Date

_____ _____
Address Phone

Revoke Authorization
To revoke this authorization, I must mail or fax my written request along with a copy of this original authorization to: Health Information Department, Atlantic General Hospital , 9733 Healthway Drive, Berlin, MD 21811, Phone: 410-641-9614, Fax: 410-641-3410
If I am unable to provide a copy of the original authorization with my request to revoke, I will provide the following information: Date of the authorization, Name, Address, Phone number, Medical record number, Social security number, Date of birth, Purpose of authorization, A description of the health information covered by the authorization, The person or entity authorized to use the data.
If the form was signed by my representative, the request will also include: The representative's name, Relationship, Address and Phone number.
I understand that if I am unable to provide all of the above information, Johns Hopkins may not be able to honor my revocation request.

ATLANTIC GENERAL HOSPITAL
9733 Healthway Drive
Berlin, MD 21811
Phone: 410-641-9173
Fax: 410-641-9036

Women's Diagnostic Center
Breast Imaging Request
Release of Health Information