UNIVERSITY OF MARYLAND MEDICAL CENTER
UNIVERSITY OF MARYLAND MEDICINE

22 South Greene Street
Baltimore, Maryland 21201-1595
410-328-5706
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TDD: 410-328-9600

HISTORY # _____

HEALTH INFORMATION MANAGEMENT SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the UMMC or _____(*name of facility*) to release my medical record information including dates, history of illness, diagnostic and therapeutic treatment. The medical records to be released may contain medical information pertaining to psychiatric, drug and/or alcohol and diagnosis and treatment.

Patient information:

_____
Last Name **First Name** **Middle Initial**

_____
Address **Apt. #**

_____
City **State** **Zip Code**

_____ _____ _____
Date of Birth **Social Security #** **Telephone #**

Please release records covering the time period for _____to _____

Information to be released:

( ) Complete copy ( ) Other _____

( ) Abstract ( ) Other _____

Purpose of disclosure: ( ) Continuum of Care ( ) Insurance ( ) Self ( ) Other _____

***** Please note a fee may be charged for copies of the medical record. *****

Information to be released/sent to: _____

_____

- I understand the Medical Center may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- In addition, I authorize disclosure of medical records received from other providers. (Note: the disclosures of records furnished by other providers may be prohibited by those providers.)
- I understand this authorization shall expire in one year from the date noted below and can be revoked in writing at any time as provided in the Medical Center's Notice of Information Privacy Practices. Such a revocation will not cover disclosures made previously in reliance on this authorization.
- The Medical Center, its employees, officers and medical staff are released from legal responsibility or liability for the release of the information in accordance with this authorization.
- I understand that the person/company receiving this information may not be subject to laws on confidentiality of medical information and may redisclose it.

Signed: _____
(Patient or Representative) (Date)

If not signed by Patient; authority to act for minor or incompetent patient:
( ) Parent ( ) Guardian ( ) Power of Attorney ( ) Closest Family Member consenting for patient's care

Witness: _____