AF

**Release of Information Authorization Form**
For the Use and Disclosure of Protected Health Information by Garrett Regional Medical Center

Hospital use only:
Medical Record #_____
[ ]Mail [ ]Fax [ ]Pick up [ ]CD
Date needed:_____

WVU Medicine
GARRETT REGIONAL MEDICAL CENTER

| Patient Name (print): | | Date of Birth: | |
|---|---|---|---|
| Address: | City: | State: | Zip: |
| Telephone Number: | Fax Number: | | |
| Social Security Number: | | | |
| Method for receiving records: [ ]Mail [ ]In Person [ ]Other: | | | |
| [ ] E-mail: I understand email is an unsecured communication. I have been informed of the risks and authorize my information to be sent to | | | |

| **Bi-directional Authorization to release protected health information** (please check all that apply) |
|---|
| ☐ Discuss my protected health information with: |
| ☐ Obtain copies of my protected health information from: |
| ☐ Release my protected health information to: |

**To use or disclose to:**

| Name of Person or Facility: | | | |
|---|---|---|---|
| Address: | City: | State: | Zip: |
| Telephone Number: | Fax Number: | | |
| Email: | | | |
| Reason for Release: | | | |

| **Put a <u>CHECKMARK</u> next to the specific documents that apply to your request:** | **Dates of Service:** |
|---|---|
| [ ] Emergency Room | |
| [ ] Laboratory Reports | |
| [ ] Outpatient Surgery Records | |
| [ ] Consultation Reports | |
| [ ] Billing Records | |
| [ ] Inpatient Hospital Records | |
| [ ] Other Outpatient Department Records | |
| [ ] Subacute Records | |
| [ ] Clinic Notes (outpatient) | |
| [ ] Radiology Reports<br>[ ] CD [ ] Films [ ] Other_____ | |
| [ ] Other: | |

The undersigned understands and agrees that the information to be used or disclosed pursuant to this authorization form may include information relating to:

(1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV);
(2) treatment for drug or alcohol abuse;
(3) mental or behavioral health or psychiatric care

**I UNDERSTAND THAT:**

- I may revoke this Authorization at any time by notifying Garrett Regional Medical Center in writing to Health Information Management, 251 North Fourth Street, Oakland, MD 21550.
- A revocation will not have any effect on any information already used or disclosed by Garrett Regional Medical Center before Garrett Regional Medical Center received my written notice of revocation.
- Unless earlier revoked, this authorization will expire on the 180th day of the signing or as otherwise specified below.
- If neither Federal or Maryland privacy law applies to the recipient of the information, the information disclosed according to this authorization may be re-disclosed by the recipient and no longer protected by Federal or Maryland law.
- I may inspect and receive a copy (Maryland law establishes nominal fees for copy charges of medical records) of the information to be used and disclosed pursuant to this Authorization form.
- This Authorization is voluntary and I may refuse to sign this Authorization form.
- I am not required to sign this Authorization form in exchange for the patient receiving treatment from Garrett Regional Medical Center.

If I am providing authorization for marketing purposes, I understand that Garrett Regional Medical Center may receive remuneration from a properly authorized business associate as a result of using the PHI.

By signing this Authorization Form, I understand that I am giving my authorization to Garrett Regional Medical Center's designated medical record or database custodians to use and/or disclose my protected health information (PHI), as described above to the following person(s) or organization(s):

**I have read and understand the information in this Authorization form.**

| | | |
|---|---|---|
| Signature of Patient or Surrogate Decision Maker: | | |
| Printed Name of Patient or Surrogate Decision Maker: | Date:<br>____ - ____ - 20____ | Time: |
| Relationship to Patient giving authority to act for Patient (if applicable): | | |
| Witness: | Date:<br>____ - ____ - 20____ | Time: |

| **Office Use Only** | |
|---|---|
| ☐ ID Checked<br>Processed Date: _____<br>Processed By: _____<br>Total Pages: _____ | Additional Notes: |