Dimensions Healthcare System

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name ______________________________ Date of Birth: ____________________
Address ______________________________ SS #: ____________________
______________________________ Phone: ____________________

I hereby authorize (***Hospital/Program***) ______________________________ to release my medical records which may contain information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, HIV/AIDS results or HIV/AIDS. (***Date of service***)______________________________.

Please release my medical record to ***(Complete name and address)***: ______________________________
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Please release the following information in my medical record ***(Check all that apply)***:

- ☐ Admission History & Physical
- ☐ Consultation Report
- ☐ Lab Report
- ☐ Discharge Summary
- ☐ Other ______________________________
- ☐ Emergency Room Record
- ☐ X-rays/ Imaging Studies
- ☐ Operative/Pathology Report
- ☐ Abstract (Summary of Medical Record)
- ☐ Entire Medical Record

Please complete each of the following statements. If not completed, the following information will not be released.

I ☐ do ☐ do not want HIV/AIDS information released under this authorization.
I ☐ do ☐ do not want mental health information released under this authorization.
I ☐ do ☐ do not want drug/alcohol abuse treatment information released under this authorization.
I ☐ do ☐ do not want developmental disability treatment information released under this authorization.

The purpose for release of the above information:

☐ Continued Care ☐ Insurance ☐ Legal ☐ At my request ***(Patient only)*** ☐ Other: ____________________

This authorization will expire within 1 year unless otherwise indicated. I understand that authorization is voluntary and may be revoked by me at the time in writing except to the extent that action has already been taken in reliance this authorization. Subsequent re-disclosure or recopying of this information is not authorized without specific consent of the patient or authorized representative as provided in the Annotated Code of the State of Maryland, Article 4-302 (d). I understand that I do not have to sign this authorization to ensure that I receive medical care. ***Photo ID* is required at the time of release.**

______________________________ ____________________
Signature of Patient **Date**

______________________________ ____________________
Signature of Parent, Guardian, or Legal Representative **Witness**

If signed by other than patient, state relationship and reason for patient's inability to sign.______________________________
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Verbal consent requires the signature of two (2) witnesses:

Signature of Witness ______________________________ Date: ____________________

Signature of Witness ______________________________ Date: ____________________

White = Dimensions Copy **Yellow = Patient Copy**

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

2-201 (3/07)