AF

Authorization Form

Hospital Use Only:
Medical Record Number _____
[ ] Mail [ ] Fax [ ] Pick Up

Date Needed: _____

For the Use and Disclosure of Protected Health Information by Garrett County Memorial Hospital

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Patient Name (print): _____
Patient Address: _____City:_____State:_____Zip:_____
Social Security Number: _____
Date of Birth: _____
Telephone Number: _____Fax Number: _____

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

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must Name of Person(s) or Organization(s): _____

be Street Address: _____

filled City, State and Zip Code: _____

in Telephone Number: _____ _____ _____

Fax Number: _____

I specifically authorize the use and disclosure of the following PHI: (Please provide a detailed description of the particular **data** and **dates** you are requesting)

[ ] Emergency Room Records _____

[ ] Inpatient Hospital Records _____

[ ] Laboratory Reports _____

[ ] Radiology Reports _____

[ ] Outpatient Surgery Records _____

[ ] Other Outpatient Department Records _____

[ ] Consultation Reports _____

[ ] Sub Acute Records _____

[ ] Other _____

If this authorization is for any purpose other than the release of medical records for personal reasons, please state the purpose of the authorization to release PHI below:

_____

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 may revoke this authorization at any time by notifying GCMH in writing to Health Information Management Department, 251 N. Fourth Street, Oakland, MD 21550. I understand that such a revocation will not have any effect on any information already used or disclosed by GCMH before GCMH 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 nor Maryland privacy law applies to the recipient of the information, I understand that 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.

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

I understand that I am not required to sign this Authorization form in exchange for the patient receiving treatment from GCMH.

_____ _____

Signature of Patient or Surrogate Decision Maker Date

_____

Printed Name of Patient or Surrogate Decision Maker

_____

Relationship to Patient giving authority to act for Patient (if applicable)

_____ _____

Witness Date