

LUTHERVILLE SURGERICENTER, LLC
AUTHORIZATION for RELEASE of MEDICAL INFORMATION

Print patient's full name

Birth date (Mo/Day/Yr)

(Street address)

Social Security number

(City, State, Zip code)

Phone number (Home)

At the request of the individual, I _____, do hereby authorize Greater Chesapeake Hand Specialists, P.A. to release: **(Patients name)**

_____ DISCHARGE SUMMARY	_____ PATHOLOGY REPORTS	_____ EMERGENCY REPORTS
_____ HISTORY & PHYSICAL	_____ LABORATORY REPORTS	_____ OTHER
_____ PROGRESS NOTES	_____ RADIOLOGY REPORTS	
_____ OPERATIVE NOTES	_____ ECG/EEG/CARDIC CATH	_____

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

NAME (Physician, attorney, hospital, agency, etc)

Street address

City, State, Zip

PURPOSE of DISCLOSURE

_____ REFERRAL to SPECIALIST	_____ INSURANCE	_____ WORKERS COMP
_____ LEGAL INVESTIGATION	_____ DISABILITY DETERMINATION	_____ PERSONAL

OTHER (SPECIFY) _____

I hereby authorize disclosure of the health information for the above named patient. I understand that I may cancel this request with written notification but that it will not effect any information release prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization expires on _____, 200____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

Signature of individual or guardian or Personal Representative of patient's estate

Date

Reason for transferring: _____

Please provide current day-time telephone number in the event we need to contact you: _____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with Healthport to make copies. You may be required to pre-pay for the copies; if not, then copies will be mailed along with an invoice.

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE _____	LAB _____	MAMMOGRAM _____	_____
DS _____	EKG _____	NUMBER of PAGES _____	ROI SPECIALIST
OP _____	X-RAY _____	OTHER _____	_____
HP _____	PATH _____	_____	DATE