CalvertHealth Medical Group

Authorization for the Release of Health Information

(Requesting Medical Records *From* CHMG)

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFP 4-310-04-307. **Give the completed form to your provider or fax to them at: _____**

Patient Information:

Name: _____ SSN: _____

Date of Birth: _____ Telephone: _____

Address: _____

Release of my information:

I, _____, do hereby authorize _____ to

(patient name or representative) **(CHMG Provider and Practice Name - REQUIRED)**

release the protected health information to the following person/organization:

Name of person or organization: _____

Address: _____

Telephone: _____ Fax: _____

☐ Mail ☐ Fax ☐ Mail to patient ☐ Patient pick up ☐ Patient Portal

Information to be released:

Date range of information to be released: From: _____ To: _____

☐ All medical records (may include HIV/AIDS, Behavioral Mental Health, drug/alcohol abuse and genetics)

☐ Patient Account (Billing) ☐ Other (Please specify): _____

Purpose of Information Release

☐ Treatment/Continuation of Care ☐ Payment of insurance claim ☐ Legal Purposes

☐ Disability determination ☐ Applying for insurance ☐ Other (please specify): _____

I understand:

- This authorization is voluntary. My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditional on my signing this form.
- I may inspect my protected health information without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke the authorization, I understand that I must notify CalvertHealth Medical Group (CHMG) in writing.
- I understand that once information covered by this authorization has been disclosed, re-disclosure of this information by the recipient is possible and I understand the information may no longer be protected by the federal regulations referenced above, but may be protected by Maryland law.
- For copies made for an insurance company, attorney or an employer, CHMG or its agents will receive payment or other remuneration from a third party in exchange for using or disclosing the above information.
- If I am requesting Medical Records for any purpose other than continued care, I agree to pay the following:

  $0.76 per page PLUS $22.88 in administrative fees.
- I will not be charged if the medical records I am requesting are being sent directly to a provider for purposes of continuation of care.
- I acknowledge that and understand that the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS and genetics.
- This authorization will **expire 6 months from date signed**, unless earlier date is identified: _____.

Minor Signature and Authorization:

Please note: if the information relates to the treatment of pregnancy, drug or alcohol abuse, venereal disease, or emotional disturbance for a patient under the age of 18, the patient must sign this authorization.

Signature of Patient, Legal Guardian/Representative: _____ Date: _____

If Legal Guardian/Representative, print name: _____

If signature is other than the patient, explain your authority to act for patient: _____

For CHMG use only

Date rcvd: _____ Rcvd by: _____ Delivery Method:

Date released: _____ Processed by: _____ ☐ By Mail ☐ Picked up in person

MRN: _____ Scanned: _____ Cost: $_____ ☐ By fax ☐ Patient Portal