



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

Date needed: _____

GARRETT REGIONAL MEDICAL CENTER

A Proud Affiliate of
WVU Medicine

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)
<input type="checkbox"/> Discuss my protected health information with:
<input type="checkbox"/> Obtain copies of my protected health information from:
<input type="checkbox"/> 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 CHECKMARK 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 [] 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: ____ - ____ - 20____	Time:
Relationship to Patient giving authority to act for Patient (if applicable):		
Witness:	Date: ____ - ____ - 20____	Time:

Office Use Only	
<input type="checkbox"/> ID Checked Processed Date: _____ Processed By: _____ Total Pages: _____	Additional Notes: