CARROLL OCCUPATIONAL HEALTH
Affiliated with Carroll Hospital Center

Authorization to Release/Receive Medical Records

Patient Name:

I, _____ _____ hereby authorize
(your name) (your telephone number)
_____ to release the medical records of _____
(entity to release records) (patient's name)
to _____.
(entity to release records)
This may include information about serious communicable diseases and/or infections as defined by Maryland statute and Department of Public Health rules, which include Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), venereal disease and tuberculosis, if any; alcohol and/or drug abuse information protected under the regulations of 42 CFR Part 2, if any; psychiatric/psychological records, if any; social work records, if any; including communications made by me to a social worker, psychiatrist, or psychologist.

Birthday of Patient	Mail to Attention
Phone No.	Fax No.
Date(s) Treated	Name Used at Time of Treatment

RECORDS TO BE RELEASED

o Anesthesia Records	o Lab Reports	o Radiology Reports
o Cardiology Reports	o Medication/IV Records	o Xray Films
o Consultation Report	o Operative Report	
o Discharge Summary	o Pathology Report	o Complete Medical Record
o ER Record	o Physical Therapy Notes	o Other (Specify)
o Face Sheet	o Progress Notes	_____
o History and Physical	o Psychological Reports	

PURPOSE OF DISCLOSURE

o Continuation of care	Physician's Name:	o Insurance Billing Verification	Company Name:

o Other (specify)

This authorization must be signed subsequent to the service date you are requesting and may be revoked at any time by notifying the entity named above in writing, except to the extent that action has already been taken based on this authorization. If not previously revoked, this authorization will terminate one (1) year from the date of signing. A photocopy or electrostatic copy will have the same authority as the original. Any redisclosure of medical information by the recipient(s) is strictly prohibited. I understand that if the entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Signature X	Date	Signature of Witness X	Date

o I.D. Check

Relationship to Patient _____
(Note: If patient is unable to sign, the legal guardian or personal representative may sign. Proper court papers must be presented.)

FOR PATIENTS REQUESTING XRAY FILMS

Xray films are the property of the service provider and requesting physicians are not authorized to keep them. If lost, original films cannot be replaced. When taking original films, patient acknowledges their responsibility to return the films within a reasonable period of time after completion of their appointment. Upon written request, original mammogram films may be permanently transferred.