MOUNTAIN LAUREL
MEDICAL CENTER

1027 Memorial Drive, Oakland, MD 21550 ~ 104 Parkview Drive, Grantsville, MD 21536
301-533-3300(Oakland) ~ 1-844-652-8735(Grantsville)
Fax 301-533-3299

# *Authorization for Release of Medical Information*

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip code: _____ Phone: _____

| Persons/organizations providing the information: | Persons/organizations receiving the information: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please check REASON for disclosure of health information:
□ Transfer Medical Care □ Continue Care at Mountain Laurel □ Legal □ Personal Use

****Please Specify Records to be Released****

□ Newborn Records & Screening
□ *Last Three* Office Visits □ *Last Three* Pap Smear Results □ *Last* Complete Physical
□ Hgb/Hct & Lead Testing Results
***MOST RECENT:*** □ Mammogram □ Colonoscopy □ Immunizations
□ Most *recent* records pertaining to: _____

**HIV, Psychiatric care, and Substance Abuse Information** contained within the records indicated above **will be released** through this authorization **unless otherwise indicated below.**

**DO NOT RELEASE: ____HIV ____PSYCHIATRIC ____SUBSTANCE ABUSE**

I understand I may revoke this authorization at any time by notifying the providing organizations in writing, but if I do, it will not have any effect on any actions they took before they received the revocation. The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization. Information disclosed pursuant to this authorization is subject to re-disclosure by the recipient and no longer protected by HIPAA.

Signature of patient or patient's representative: _____ Date: _____

Witness:_____ Date: _____

Printed name of patients representative: _____

Date Records Mailed/Picked Up: _____

*Authorization expires within 6 months of date signed or at patient's request