Cardiovascular Specialists of Frederick, LLC

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Authorization for Use and Disclosure of Protected Health Information

I hereby authorize the transfer of my protected health information:

FROM:_____ **TO:**_____

_____ _____

_____ _____

Reason for request:

☐ Personal Copy ☐ Continuing Care ☐ Other_____

Information to Be Disclosed:

☐ Office Chart Notes ☐ ER reports ☐ History and Physical Exam
☐ Diagnostic Reports ☐ Discharge Summary ☐ Other: _____
☐ Laboratory Report ☐ Hospital Consults _____
☐ Procedure Reports ☐ Urgent Care Records _____

By signing this authorization form, I acknowledge that:

1) Authorizing the release of my protected health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
2) I may revoke this authorization in writing at any time except to the extent that action has already been taken to fulfill this request. Maryland law allows authorizations to remain valid for a maximum of one (1) year from date signed.
3) If the person or organization authorized to receive the information is not a health plan, healthcare clearinghouse, or healthcare provider, the information released may no longer be protected by federal privacy regulations.
4) Medical records may contain sensitive heath information such as HIV testing, treatment for drug or alcohol abuse, and behavioral or mental health information. These are specially protected by state and federal law.
   I wish to ☐ *include* ☐ *exclude* this information. ***If no selection is made, this information will be excluded***
5) Requests for medical records are subject to reproduction fees in accordance with federal and state regulations. **For requests exceeding five pages, a fee of .50 cents per page may apply.** Please speak with the medical records department for additional details.

Patient Name_____ Patient DOB _____

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable):
☐ Power of Attorney ☐ Court appointed guardian
☐ Parent or guardian of unemancipated minor
☐ Executor or administrator of decedent's estate
**Official documentation must be presented if not on file*

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IMPORTANT: Missing or incomplete information may result in a delay in processing your request.