

DOCTORS COMMUNITY HOSPITAL
8118 Good Luck Road, Lanham, MD 20706
Authorization to Disclose Health Records

Date: _____

Name of Patient: _____ MR #: _____

Address: _____

Phone Number: _____ Date of Birth: _____ Social Security Nbr: _____

Information requested: There are fees for copying/viewing and these will vary depending on the request.

____ Abstract/Summary ____ Results from Diagnostic Testing ____ Entire Health Record ____ Emergency Room Record
____ Laboratory Specimen ____ Radiographic Films ____ Cardiac Catheterization Images
____ Specific item: _____

Purpose: [] appointment with _____ on _____
[] at own request, legal, insurance, other

Arrangement to receive the information: information will be mailed within 30 days or you will be called to view/pick up the information.

____ Viewed at the hospital
____ Picked up at the hospital by: [] self [] other: _____ at the HIS/Medical Records Dept.
____ Mailed to: (Name & Address) _____

Things you should be aware of:

1. No limitations are placed on dates, history or illness, or diagnostic and therapeutic information, including any treatment pertaining to psychiatric, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), drug and/or alcohol related illness unless specified: _____
2. This authorization shall be valid for one year unless specified below and/or revoked in writing, which may be done at any time, unless DCH has already disclosed the information. The expiration date of this authorization if less than one year is _____.
3. This information may be subject to re-disclosure by the recipient and is no longer protected by this hospital.
4. The hospital does not condition treatment or payment on whether an individual signs the authorization unless the provision of health care is solely for the purpose of creating information for disclosure to a third party.

Name: _____ Witness name: _____

Signature: _____ Witness signature: _____

Telephone Number: _____ Relationship of Witness: _____

For DCH HIS/Representative Use Only:

This form was completed by: ____ patient or ____ person in interest, defined as _____

Verification of identify of person completing Authorization above:

Done by: _____ Method: driver's license, photo id, passport, _____

Dept: _____ Date: _____

Authorization deemed: ____ valid ____ invalid because _____

For Recipient and DCH Departmental Use:

The following was disclosed to the recipient: ____ Original material that must be returned to DCH within 30 days.
____ Copy of original material that does not need to be returned to DCH.

Recipient Name: _____ Signature: _____

Relationship to Authorization Name: _____

Identification verified by: _____ Dept: _____ Date: _____

____ Disclosure not made because _____ (patient didn't pick it up, info couldn't be found)

Department to complete and return to HIS:

____ Disclosure not made because _____ (patient didn't pick it up, info couldn't be found)
____ Material disclosed and returned.
____ Material not returned by Authorized Recipient.