# Eastern Shore Rural Health System, Inc.
## Authorization for Release of Information / Obtaining Health Records

| **Information Requested for:** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Patient Name: | | | | Date of Birth (Mo./Day/Yr.): | | | |
| Former Name: | | | | Medical Record #: | | | |
| Address: | | City: | | State: | | Zip: | |
| Day Phone: | | Email: | | | | | |

| **I Hereby Authorize** | **To Disclose my Protected Health Information To** |
|---|---|
| **Name** | **Name** |
| **Address** | **Address** |
| **City, State & Zip** | **City, State & Zip** |
| **Phone** | **Phone** |
| **Fax** | **Fax** |

**Information to be Released** | **Dates Requested (Year to Year): _____ to _____**

| | | |
|---|---|---|
| ☐ Verbal Communication | ☐ Exam Progress Reports _____ | ☐ Lab / X-Ray Reports _____ |
| ☐ Discharge Summary _____ | ☐ History and Physical _____ | ☐ Medication Records _____ |
| ☐ Emergency Records _____ | ☐ Immunization Records _____ | ☐ Other _____ |

**I specifically authorize the release of information relating to:**

☐ Substance Use / Substance Use Treatment (Including Alcohol / Drug Use)
☐ Mental / Behavioral Health Treatment
☐ HIV Related Information (e.g., AIDS-Related Testing)

- I understand that my substance use disorder treatment records, if any, are protected under Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise required for by the regulations, by other applicable law, or by an Order of a court.

**Purpose of Disclosure: There is no charge for copies sent to facilities for on-going care.**

| | |
|---|---|
| ☐ Transfer of Care | ☐ School / Academic |
| ☐ Consultation | ☐ Legal (Please Specify): **_____ |
| ☐ Coordination of Care | ☐ Personal Access (Specify): ** ☐ Copy ☐ Inspection ☐ Summary |
| ☐ Disability | ☐ Other (Please Specify): _____ |

** **Charges may apply**. Prior to release charges will be discusses with requestor.

**Method of Delivery of Records: To be determined based on number of pages and electronic capabilities.**

**Patient Understanding:**

- I certify that I am 18 years of age or older or am the legal representative (e.g., parent, legal guardian, legal custodian, conservator, guardian *ad litem*, attorney-in-fact under a power of attorney, or executor of decedent) of the service recipient, excepting in circumstances whereby I have medical consent to services as designated by State and / or Federal Law (i.e., Substance Use, Mental Health Treatment, Sexually Transmitted Disease Treatment).
- I understand that the records I authorize for release may include information about family planning services and communicable diseases. I also understand that by authorizing release of records, there may be limited information included about substance use and/or behavioral health diagnoses and treatment in the record.
- I understand that this authorization is valid for 12-months from the date of signature and that I may revoke this authorization by written notification signed by me, and that it will not affect any information released prior to written notification of revocation.

| | | | | |
|---|---|---|---|---|
| **Patient / Legal Representative Signature:** | | | **Date:** | |
| **Relationship to the Patient:** | | | | |
| **Records Received By:** | | ☐ **ID Verified** | **Date:** | |