bweye

Medical Record Release Form

200 Hospital Drive, Suite 600/115 Tel# 410/766.3937

Glen Burnie, MD 21061 Fax# 410/766.2904

_____ _____

Patient Name Guardian/Authorized Party Name (if applicable)

XXX-XX- _____ _____

Last four of SSN **Date of Birth**

I authorize the use and disclosure of my health information as described below:

***PLEASE SELECT ONE**

_____ Records relating to treatment dates from: _____ to _____

_____ Records of all care at this facility

_____ Other (please specify)

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made base upon my original permission (2) the authorization was obtained as a condition of securing the insurance coverage and the insurer by law has the right to consent a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire in 90 days from today's date.

I understand that it is possible that information used or disclosed with me permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

IN ORDER TO RELEASE OR RETRIEVE ANY RECORDS THIS PORTION MUST BE FILLED OUT <u>COMPETELY</u>

Information to be released To [ ] From [ ] Name/Company _____

Address/Company _____

Phone # _____ Fax# _____

To [ ] From [ ] Baltimore Washington Eye Center

200 Hospital Dr. Glen Burnie, MD 21061

Phone# 410.766.3937 Fax# 410/766.2904

_____ _____

Patient Signature Date

[ ] **This patient is a minor**. By singing this form I am the patients Parent/Guardian and I authorize the release of these records.

_____ _____

Signature of Patient/Guardian Date

A faxed copy or photocopy of this consent shall be as valid as the original.

If my medical records include information regarding drug abuse, alcoholism or psychological/psychiatric conditions,

[ ] I DO [ ] I DO NOT authorize release of this information.

*****FEE SCHEDULE:** State and Federal Law specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee is $15 for the first 10pages and $.30 for each additional page. **No fee shall be charged for forwarding records directly to other physicians.**