University of Maryland Medical System
HIM Department, Release of Information
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REQUEST FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (print) _____ Complete Address _____

Date of Birth _____ XXX-XX-_____ Last 4-digits of SS# Daytime Telephone Number _____

INFORMATION TO BE RELEASED/RECEIVED FROM:

Check the UMMS Affiliate: ☐UMMC ☐UMMC Midtown ☐UM SJMC ☐UM BWMC ☐UM CRMC ☐UM HMH ☐UM CAP ☐UM Rehab & Ortho Institute ☐UM Shore Easton ☐UM Shore Dorchester ☐UM Shore Chestertown ☐UM UCMC

Other Provider Name/Organization: _____

Address: _____

Phone #: _____ Fax #: _____

SEND INFORMATION TO: ☐ Myself at the address above unless noted below. ☐ Affiliate name above _____

Provider Name/Organization: _____

Address: _____

Phone #: _____ Fax #: _____

FORMAT OF INFORMATION TO BE DISCLOSED:

_____ Paper _____ Electronic (CD/Thumb drive) _____ Email (pdf format) Address: _____

_____ MyPortfolio (pdf format) **By signing below you acknowledge that the security of transmission is not guaranteed.**

INFORMATION TO BE DISCLOSED:

SERVICE TYPE	DATE FROM	DATE TO	SPECIFIC INFORMATION	SPECIAL REQUEST
_____ Inpatient	_____	_____	_____	☐ Radiology Images
_____ Outpatient	_____	_____	_____	☐ Itemized Bill
_____ Emergency	_____	_____	_____	☐ Radiology Report
_____ Other	_____	_____	_____	☐ Pathology Report

CHANGING STATUS: I understand the manner in which my clinical data is shared via the UMMS HIE participation, and I wish to change my status as denoted below:
Please initial one: _____ Opt-Out; - OR - _____ Opt-In (if currently in an Opt-Out Status)

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Furthermore, I understand that this information has been disclosed from records protected by federal law (42 C.F.R. Part 2). These records are prohibited from further disclosure without written patient consent unless otherwise mandated by law. Only such records and/or information believed necessary for the purpose expressed above shall be released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this request, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this request. This request will expire on _____

If I fail to specify an expiration date or event, this authorization will expire one year from the date it was signed and is only valid for information preceding this date. I understand that I may receive a copy of this form after I sign it and inspect and copy information to be used or disclosed. **I also understand there may be a charge for this information.**

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure treatment.

Date _____ Signature of Patient or Representative _____ Relationship to Patient* _____

*If not signed by patient or parent of a minor, authorizing documentation is required.