Mt. Washington Pediatric Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize Mt. Washington Pediatric Hospital (MWPH) to use and disclose the protected health information (PHI) noted below:

Patient Name: _____ Date of birth (MM/DD/YYYY): _____

Address: _____ Phone: _____

Indicate the specific information you are requesting:

□ Inpatient Abstract (history and physical, discharge summary, lab, radiology and other diagnostic testing)

□ Discharge Summary	□ Progress Notes	□ Mental Health Records
□ History and Physical	□ Immunization Records	□ Radiology Images (CD/DVD)
□ EKG/Cardiology Reports	□ Rehabilitation Evaluations	□ Billing Records
□ Lab/Radiology Reports	□ Consultation Reports	□ Other _____
	□ Outpatient Clinic Notes	

Please indicate the date(s) of service _____

Purpose of the disclosure:

□ Continuing care/treatment □ School □ Disability determination □ Insurance □ Legal purposes

□ Other: _____

Mt. Washington Pediatric Hospital should send my medical records to:

Recipient Name: _____

Address and Telephone Number: _____

_____

How would you like your records delivered? (please check the format below)

☐ PAPER ☐ CD ☐ USB (flash drive) ☐ FAX _____

Mt. Washington Pediatric Hospital

- This authorization will expire one year from the date signed, unless I revoke this authorization.
- I understand that I may revoke this authorization in writing at any time by mailing or faxing a written revocation to the Health Information Management Department, except to the extent that action had been taken by Mt. Washington Pediatric Hospital or its employees or agents prior to receipt of the revocation.
- I understand that this authorization is voluntary. I can refuse to sign this authorization and my treatment, payment, enrollment, or eligibility for benefits will not be impacted on my signing this authorization.
- I understand that I may inspect or receive copies of information to be used or disclosed as provided in 45 CFR 164.524.
- The medical information released may contain information related to sexually transmitted diseases, HIV, AIDS, behavioral or mental health, drug and alcohol abuse.
- I understand that once my health information is disclosed, the information may possibly be re-disclosed by the facility/person(s) receiving it and may no longer be protected by federal and state privacy laws.

Please print your name and sign below:

_____/_____
Name of Patient or Personal Representative (please print) Date

_____/_____
Signature of Patient or Personal Representative Date

Please check the appropriate box:

☐ Parent with Parental Rights ☐ Patient is 18 or older ☐ Court Appointed Guardian**
☐ Registered Kinship Care Relative**

**Note: You must attach proof of your authority to act on behalf of the patient.

****Please note a fee may be charged for copies of the medical record****

Fax the completed form to: **410-578-0567 or return by mail to:**
Mt. Washington Pediatric Hospital
Attn: HIM Department
1708 W. Rogers Avenue
Baltimore, Md. 21209-4596

PHITOOUT

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