(Mt. Washington staff to add this information)
Place Label Here or Insert the following:

_____/_____ _____
Last Name *First Name* *Med Rec #*

_____/_____/_____ _____
Date of Birth Date of Service

Mt. Washington Pediatric Hospital

1708 West Rogers Avenue, Baltimore, MD 21209

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By my signature below, I authorize Mt. Washington Pediatric Hospital (MWPH) to use and disclose the protected health Information ("PHI") identified below:

Concerning: _____ _____
(Patient's Name) Patient's Date of Birth

Release information to: _____
(Name of person or Facility receiving this information)

_____
Address

_____
City, State, and Zip code

Information is for the following purposes (check all that apply):

( ) School ( ) Parental Request ( ) Disability Determination ( ) Treatment
( ) Litigation ( ) Primary Care Provider ( ) Insurance Purposes ( ) Personal Use/Self
( ) Other

Please indicate the specific information you wish to obtain/ have released:
( ) Inpatient Record - Treatment Date(s) _____
( ) Outpatient Record - Treatment Date(s) _____

Specific information needed:
( ) Admission History/Physical ( ) Radiology/EKG/Lab Reports ( ) Consultation Reports
( ) Discharge Summaries ( ) Rehabilitation Evaluations ( ) Photographs
( ) Psychology Evaluations ( ) Progress Notes ( ) Other_____

Additional Instructions: _____

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

I understand that I may revoke this authorization in writing at any time except to the extent that Mt. Washington Pediatric Hospital or its employees or agents have acted upon this authorization. My written revocation must be submitted to:

Privacy Officer, Mt Washington Pediatric Hospital,
1708 West Rogers Avenue, Baltimore, Md. 21209

PHITOOUT

Mt. Washington Pediatric Hospital

(Mt. Washington staff to add this information)
Place Label Here or Insert the following:

_____/_____ _____
Last Name *First Name* *Med Rec #*

_____/_____/_____ _____
Date of Birth Date of Service

I understand that if the organization authorized to receive the information is not a health plan or health care provider, re-disclosure of the released information may no longer be protected by federal privacy regulations, but may be protected under Maryland law.

I understand this authorization is voluntary. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

I understand that I may receive a copy of this form after I sign it.

_____/_____
Signature of Patient or Patient's Representative Date

_____/_____
Printed name Phone #

This authorization will expire on: _____
(Expiration is one year from the date recorded above)

Please check the appropriate box:

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

**Note: You must attach proof of your authority to act on behalf of the patient unless a copy of this is already in the patient's chart.

For questions concerning this form or other release of information questions, call
410-578-2657 HIM/Medical Records Department

Fax Completed and Signed Form to: 410-578-0567
Or
Mail to: Mt. Washington Pediatric Hospital
Attn: HIM Department
1708 W. Rogers Ave.
Baltimore, Md. 212 09