Greater Baden Medical Services Health Information Management 7450 Albert Road, 3rd Floor Brandywine, MD 20613 Phone: (301)-599-0463 Ext. 3339 Fax: (301) 599-0463	**AUTHORIZATION TO RELEASE COPIES OF HEALTH INFORMATION**	For Clinic Use Only ☐ Records sent from GBMS- please scan to patient record. ☐ Mailed ☐ Picked up ☐ Faxed Date Received: _____ Date Processed: _____ Processed by:_____ ☐ Forwarding Request to ROI for processing

Please complete this form in its entirety so we can help you receive the information you are requesting.

1. *This authorization is voluntary. I understand that Greater Baden Medical Services (GBMS) will not base treatment, payment, enrollment, or eligibility for benefits on my signing this document. Please see the second page for our fee schedule.*

   Patient Name: _____Maiden/AKA: _____ Date of Birth: _____
   Street Address: _____Telephone #: _____
   City, State, Zip: _____ Email Address: _____

2. **Myself:** l request GBMS to release my protected health information to myself to the address listed above.
   Select delivery method: ☐ US Mail ☐ Pick up

3. **Other:** I am the patient, or the legally authorized representative of the patient listed above and request GBMS to release my protected health information (or the patient information listed above) to:
   Individual/Person: _____Company/Organization: _____
   Street Address: _____Phone: _____
   City, State, Zip: _____Fax: _____

   Select delivery method: ☐ US Mail ☐ Pick up ☐ Fax (Health Providers Only)

   *If this request is to send records to another healthcare provider, is this a change in your primary care doctor?
   If yes, please initial for the change to be applied in your medical record _____ (initials required)

4. Purpose of release/disclosure to other person/organization:
   Reason for Disclosure
   ☐ Continuation of Care/Transfer of Care
   ☐ Attorney/Legal
   ☐ Insurance Company
   ☐ Workman's Compensation
   ☐ Other
   (specify):_____

5. **Record set to be released to the party indicated above:**
   I request the following information be released, which may include: *alcohol and drug abuse/treatment*; *psychological and social work counseling*; *HIV*, *AIDS or ARC*; *communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis*; *genetic information and demographic information, for the purposes and conditions designated on this form.*

   The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ Problem list	☐ Laboratory results	(from _____ to _____)
☐ List of allergies	☐ X-ray and imaging reports	(from _____ to _____)
☐ Medication list	☐ Consultation reports	(from _____ to _____)
☐ Immunization record	☐ Billing information	(from _____ to _____)
☐ Most recent physical	☐ Entire Record	(from _____ to _____)
☐ Most recent discharge summary	☐ Other:_____	

AUTHORIZATION TO RELEASE COPIES OF HEALTH INFORMATION

6. This authorization expires on: ☐ 1 year ☐ 6 months ☐ Other (*specify expiration date or event*):_____
If the expiration date is left blank, the authorization expires 60 days from the signature date.

7. Revoking (cancelling) authorization: I may revoke (cancel) this authorization at any time. Revocations (cancellations) must be made in writing and sent to the GBMS Health Information Management Release of Information at the address listed on this form. Revocations (cancellations) will not apply to information that already has been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy, or the policy itself.

8. Note: Once information has been disclosed, GBMS can no longer protect it from further disclosure.

9. Payment: There will be fees associated with most record requests. The fees are outlined below.

_____ _____
Signature as patient or legally authorized Representative (if patient or minor is unable to sign) Date (mm/dd/yyyy)

_____
Printed Name of Legally Authorized Representative (if patient or minor is unable to sign)
Relationship to patient ☐ Parent ☐ Legal Guardian ☐ Next-of-Kin : ☐ Spouse

Additional Information Regarding Your Request

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON

If you are requesting. Medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the health information. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at Law, etc. Verbal authorizations from a patient is not acceptable Please contact **Health Information Management - Release of Information at (301) 599-0460** to determine the documentation that will be required to process your request.

SUBMITTING REQUESTS & RECEIVING RECORD COPIES - Requests for medical records may be:

- Mailed to Health Information Management, Release of Information at 7450 Albert Road, Brandywine, MD 20613.
- Faxed to Health Information Management, Release of Information at (301) 599-0463.
- Submitted in person Monday-Friday to any GBMS location.

Unless otherwise noted/requested, records will be sent through US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Our average turnaround time for processing requests is ten (10) business days. Please include your phone number on your request, in case we need to contact you for additional information. **For questions regarding requests for medical record copies, please contact: Health Information Management - Release of Information at (301) 599-0460.**

FEES are authorized annually by Maryland law (Health General Sec. 4-304). Records requested for legal, insurance, or personal will require a prepayment. A fee notice will be sent to you upon receipt of your request. Actual fees are outlined below. Records fees will be billed as follows:

Patients	Attorneys and Insurance Companies
Copying Fee: 76¢ per page	Preparation Fee: $22.88
Postage handling fee: (varies)	Copying Fee: 76¢ per page
	Postage handling fee: (varies)