HOLY CROSS HEALTH

Medical Imaging Dept.
Holy Cross Hospital
1500 Forest Glen Road
Silver Spring, MD 20910
Phone: (301) 754-7738

Medical Records Dept.
Holy Cross Hospital
1500 Forest Glen Road
Silver Spring, MD 20910
Phone: (301) 754-7180
Fax: (301) 754-7175

Medical Records Dept.
Germantown Hospital
19801 Observation Drive
Germantown, MD 20876
Phone: (301) 557- 6180
Fax: (301) 557-5551

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Address: _____ City _____ State _____ ZIP _____

Date of Birth: _____ Telephone No: _____

Dates of Treatment: _____

Medical Record #: _____ Type of Visit: □ Inpatient □ Outpatient □ Emergency

Request:

❑ **Paper** ☑ **Electronic Delivery** ❑ **CD**

I AUTHORIZE THE MEDICAL RECORDS/MEDICAL IMAGING/PHARMACY DEPARTMENT TO RELEASE THE FOLLOWING INFORMATION:

❑ Summary or Abstract	❑ Operative Report	❑ Nurses Notes
❑ Entire Medical Record	❑ Anesthesia Record	❑ Emergency Room Notes
❑ Discharge Notes	❑ Pathology Report	❑ Medication Record
❑ Admission History & Physical	❑ Diagnostic/X-Ray Reports	❑ Progress Notes
❑ Consults	❑ Laboratory Results	❑ Radiology Film
❑ Physician's Orders	❑ Psychotherapy Notes or mental health records	❑ Medical Imaging CD ❑ Pharmacy Prescription Profile ❑ Other: _____

Please send information to: (Please include Full name, address, and phone number, email address (for electronic delivery)

RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054 , SOUTHFIELD, MI 48086-5054
REQUESTS@RECDEP.COM
P: 248-357-3330 F: 248-357-3337

Purpose:

❑ At my request ☑ Other: LEGAL - DISCOVERY BEFORE TRIAL

If your medical record contains any records obtained from other providers (not applicable to medical imaging), please check one:

❑ I prohibit their release:
❑ I authorize and request their release [unless prohibited by the other provider(s)].

This Authorization is valid for up to *12 months from the date of signature*, unless a shorter period is listed below.
Expiration Date or Event: _____

I understand that I may refuse to sign this Authorization. If I do not complete this Authorization, it will not affect the use or disclosure of my protected health information for purposes of treatment, payment or eligible for benefits. I can change my mind at any time and revoke in writing my permission to allow my protected health information to be used or disclosed under this Authorization, except to the extent Holy Cross Health relied on this Authorization.

I understand that Holy Cross Health will not release my protected health information to others except as authorized by me or permitted by law. Once my protected health information is shared with a group or individual that is not required to follow federal privacy laws, Holy Cross Health cannot assure that the information will remain confidential.

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

<u>For release to the patient</u>, there is a fee based on type of delivery (paper vs electronic). Electronic records sent in electronic format (CD or electronic) - $6.50. Paper records are charged based on a per page fee. For sending copies of medical records to physicians or other health care providers, there is no fee except for Radiology Film, there is a $3.00/sheet fee and no charge for CDs.
Note: Holy Cross Health has contracted with MRO to handle the release of medical record information.