AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO: _____
Fax #:_____

This will authorize you to release information concerning:

PATIENT'S NAME: _____
DATE OF BIRTH: _____
ADDRESS: _____
1. I authorize you to release the following information:

____ All Medical records
____ Discharge Summary ____ Laboratory results ____ Emergency Room/ Urgent Care ____ Operative Report
____Admission History & Physical ____ Consultation/Operative Reports ____ Other *(Specify)*_____
**See notice below regarding Federal Law Confidentiality requirements*

There records are for services provided on the following dates: _____

2. Please identify who may disclose or make use of your protected health information:
The Health Care provider may disclose/release my records: ._____
Other (describe specifically) _____

3. Please send my records to: HyperHeal Hyperbarics, Inc. – fax#: 443-330-5676
Please transfer my records to: _____
_____

4. This authorization will expire on: _____
I understand that after the Health Care provider discloses my health information, it may no longer be protected by privacy laws.

I understand that this authorization is voluntary and that I may refuse to sign the authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.

I understand that I have the right to inspect and receive a copy of the information to be disclosed and I may revoke this authorization at any time in writing, except to the extent that action has been taken on this authorization.

I understand that I may specify a date for the expiration of this authorization but that it shall expire by Law, without my express revocation, one year from the date written below, unless the patient is a resident of a nursing home.

_____ _____
Signature of Patient or Representative Date

_____
Print Patient's Name

_____ _____
Witness Date

State basis for authority to give consent on patient's behalf: _____
1. Medical care power of attorney, guardian, court order, or Letter of Administration (provide copy)
2. Relative or person authorized by Law (explain relationship)

This authorization must be signed by a party in interest as defined in Title 4 Subtitle 3 of the Health General Article of the Annotated Code of Maryland. In the case of a patient who is physically unable to sign this authorization, he or she should place an "X" on the signature line and have his or her consent witnessed.
NOTICE – To accompany release of alcohol and drug abuse records
This information has been disclosed to you for records whose confidentiality is protected by Federal Law. Federal regulations (42.C.r Part2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.