Patient information:

Name: ___________________________
Date of birth:________________________

TidalHealth
Authorization to Release Medical Information

Phone: 410-543-7075 Fax: 410-912-5794
Email: inforelease@tidalhealth.org

I, the undersigned, hereby authorize TidalHealth to release copies of protected health information (PHI) to the following recipient:

Recipient:
Name: ________________________________
Address: ________________________________
____
City: ________________________________
State: ____________________Zip code:________
Phone #:________________________________
Email:________________________________

Purpose for disclosure:
____
____
____
____

☐ Check box if disclosure is at the request of patient or authorized representative

Dates(s) of service: ____

For this authorization my "health information" is: (check all that apply):

- ☐ Complete record (ALL)
- ☐ Include information from other providers/facilities
- ☐ Admission history & physical
- ☐ Discharge summary
- ☐ Outpatient record
- ☐ Emergency room record
- ☐ Diagnostic test/results reports (lab, xrays and other test results)
- ☐ Digital images (CD)
- ☐ Operative report
- ☐ Abstract record (discharge, summary, history & physical, operative notes and test results)
- ☐ Pathology report
- ☐ Other:________________________________

<u> Please initial below if release is to include:</u>**

______ Drug and alcohol records
______ Mental Health records
______ Reproductive health records
______ Other:____________________________

MyChart (Patient Portal) access:____
Patient's email address required

Medical records received from other health care providers will not be released if re-disclosure is prohibited by that provider.

I understand that once my information is disclosed to the Recipient that the information disclosed pursuant to this authorization may be subject to redisclosure by the Recipient and no longer protected by federal privacy or security laws.

TidalHealth may not condition treatment, payment, enrollment or eligibility for benefits on providing or refusing to provide this Authorization. Unless: (a) this Authorization is for clinical research, in which case TidalHealth may condition the research-related treatment on providing this Authorization; or (b) the health care provided by TidalHealth is solely for the purpose of creating health information for disclosure to a third party (such as an employment physical), in which case TidalHealth may condition the provision of such health care on providing this authorization.
This authorization will expire in one (1) year. I understand I may revoke this authorization in writing at any time by sending a written revocation to Privacy Officer, TidalHealth Peninsula Regional, 100 E. Carroll St., Salisbury MD 21801.

____
Signature patient/representative

____
Relationship of representative

____
Street address

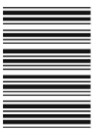
____
Representative printed name

____
City, State, Zip

____
Describe representative's authority to act for patient (if signing as a legal representative, please provide documentation to support status)

____________ ________________________
Date signed Telephone number

A copy of this authorization must be given to the patient/representative. NOTE: Standard fees may apply as allowed by law.



122