

TidalHealth Inc.
Health Information Management
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TidalHealth Authorization to Release Medical Information

- TidalHealth Peninsula Regional TidalHealth Nanticoke TidalHealth Atlantic TidalHealth Urgent Care
 TidalHealth Primary & Specialty Care - specify practitioner name or office: _____

Purpose of the disclosure: (must be filled out) _____

Patient information:

Name: _____ Date of birth: _____

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

Release to:

Name: _____ Fax: _____

Address: (include city, state and zip code if mail) _____

Phone: _____

Date(s) of service: _____

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

- | | |
|--|--|
| <input type="checkbox"/> Complete record (ALL) | <input type="checkbox"/> Behavioral health records |
| <input type="checkbox"/> Operative notes and test results | <input type="checkbox"/> Reproductive health records |
| <input type="checkbox"/> Pathology report | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Admission history/discharge summary | <input type="checkbox"/> Drug and alcohol treatment records (*SUD) records |
| <input type="checkbox"/> Outpatient record | <i>Notice: 42 CFR Part 2 prohibits unauthorized disclosure of these records.
They may not be re-disclosed except in compliance with 42 CFR Part 2.</i> |
| <input type="checkbox"/> Emergency room record | |
| <input type="checkbox"/> Diagnostic test/results reports (lab, xrays and other test results) | |


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

Proxy access name of proxy: _____ Proxy email: _____

Medical records received from other healthcare practitioners will not be released if re-disclosure is prohibited by that practitioner.

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 healthcare 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 healthcare 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.

 2 0 1 4 3 6 A	_____ 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