MOUNTAIN LAUREL MEDICAL CENTER

1027 Memorial Drive, Oakland, MD 21550 **104 Parkview Drive, Grantsville, MD 21536**
22221 Westernport Road SW, Westernport MD 21562 **198 Morgantown St, Ste. 2, Bruceton MIlls, WV 26525**
Phone: Oakland-301-533-3300 Grantsville-844-652-8735 Westernport-240-774-0204 Bruceton-304-379-7600
Fax: Oakland-833-448-0361 Grantsville-833-448-0359 Westernport-833-448-0362 Bruceton-833-448-0358

Authorization for Release of Medical Information

I hereby authorize the use and disclosure of my individually identifiable health information as described below.
I understand that this authorization is voluntary.

Patient Name: _____ **Date of Birth:** _____

Street Address: _____

City, State, Zip code: _____ **Phone:** _____

Persons/organizations providing the information:	Persons/organizations receiving the information:
_____	_____
_____	_____
_____	_____

Please check REASON for disclosure of health information:
□ Transfer Medical Care □ Continue Care at Mountain Laurel □ Legal □ Personal Use

****Please Specify Records to be Released****

□ Newborn Records & Screening
□ *Last Three* Office Visits □ *Last Three* Pap Smear Results □ *Last* Complete Physical
□ Hgb/Hct & Lead Testing Results
MOST RECENT: □ Mammogram □ Colonoscopy □ Immunizations
□ Most *recent* records pertaining to: _____

HIV, Psychiatric care, and Substance Abuse Information contained within the records indicated above **will be released** through this authorization **unless otherwise indicated below.**

DO NOT RELEASE: ____HIV ____PSYCHIATRIC ____SUBSTANCE ABUSE

I understand I may revoke this authorization at any time by notifying the providing organizations in writing, but if I do, it will not have any effect on any actions they took before they received the revocation. The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization. Information disclosed pursuant to this authorization is subject to re-disclosure by the recipient and no longer protected by HIPAA.

Signature of patient or patient's representative: _____ **Date:** _____

Witness:_____ Date: _____

Printed name of patients representative: _____

Date Records Mailed/Picked Up: _____
*Authorization expires within 6 months of date signed or at patient's request