HOLY CROSS HEALTH PARTNERS
at Asbury Methodist Village

201 Russell Avenue
Administration Building
Gaithersburg, MD 20877
301-557-2110
TTY: 301-754-7406
HolyCrossHealth.org

Federal Law ensures the privacy of your medical records, their availability to you, and special rights regarding your medical records.

As a general principle, we will always assume that you have instructed us NOT to release your medical records, or any portion thereof, to anyone, except under the usual, general circumstance covered below.

Please read and sign this GENERAL AUTHORIZATION CONCERNING YOUR MEDICAL RECORDS.

Relevant portions of my medical record may be provided to:

1. **other designated doctors and their staffs (e.g. this practice; primary or referring doctors and their staffing, hospital or outpatient facilities, endoscopy unit, or surgical-day-car).**
2. **my medical insurance company to document specific service(s) provided and billed.**
3. **the Government, as required by law (e.g. subpoena).**

If you wish to have a detailed explanation of all of the specifics and rights summarized above, now or at any time in the future, please initial "yes", below; let our staff know; and the relevant forms will be provided

_____ YES _____NO

If you wish to designate (a) person(s) (other than those above) to be given access to all or part of your medical record, or if you wish to revoke such designation, please initial "yes" and fill out the additional section below.

_____ YES _____NO

Please specify by checking the appropriate answer below, if we may leave health-related information (e.g. lab/biopsy/x-ray results, billing issues, or other doctor-patient communications) on your:

Home/Mobile voicemail _____YES _____NO

Work voicemail _____YES _____NO

(Please note that if the above section is not completed, we will assume that we have your approval to contact you using any one of these methods.)

I acknowledge that I have read and agree to the above.

_____ _____
Printed name **Date**

_____
Signature

I, _____, designate_____ the
(patient)
right to access my medical records.

_____
(patient signature and date)