

## **Medical Imaging Dept.**

Holy Cross Hospital 1500 Forest Glen Road Silver Spring, MD 20910 Phone: (301) 754-7738

## **Medical Records Dept.**

Holy Cross Hospital 1500 Forest Glen Road Silver Spring, MD 20910 Phone: (301) 754-7180 Fax: (301) 754-7175

## Medical Records Dept.

Germantown Hospital 19801 Observation Drive Germantown, MD 20876 Phone: (301) 557-6180 Fax: (301) 557-5551

## AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

	aress:		_CitySta	te		ZIP	
Dat	ee of Birth:	Tele	phone No:				
Dat	tes of Treatment:						
Medical Record #:		Type	of Visit: □ Inpatient	□ Outpatient		ent	□ Emergency
	□ Paper		<b>Electronic Delivery</b>		CD		
IA	UTHORIZE THE MEDICAL RI		MEDICAL IMAGING/PHAI OLLOWING INFORMATIO		C <b>Y DEP</b> A	ARTME	ENT TO RELEASE THI
	Summary or Abstract		Operative Report			Nurse	s Notes
	Entire Medical Record		Anesthesia Record			Emerg	ency Room Notes
	Discharge Notes		Pathology Report			Medic	ation Record
	Admission History & Physical		Diagnostic/X-Ray Reports			Progre	ess Notes
	Consults		Laboratory Results			Radio	ogy Film
	Physician's Orders		Psychotherapy Notes or menta health records	1	_ _	Pharm	al Imaging CD acy Prescription Profile
Plea						r electroi	·
_	pose:					r electron	
Pur	pose:  At my request  our medical record contains any record  I prohibit their release:  I authorize and request their re	rds obtained	Other:  from other providers (not applics prohibited by the other provide	able to	o medical	relectron	), please check one:
Pur If y	pose:  At my request  our medical record contains any record I prohibit their release:  I authorize and request their rest s Authorization is valid for up to 12 moiration Date or Event:	ds obtained lease [unles	Other:  from other providers (not applices prohibited by the other provide the date of signature, unless a shape of signature.	cable to r(s)]. norter p	o medical	imaging	), please check one:
Pur  If y  Thi  Exp	pose:  At my request  our medical record contains any record  I prohibit their release:  I authorize and request their resess  Authorization is valid for up to 12 n	rds obtained lease [unles nonths from ation. If I d ent or eligib	Other:	eable to r(s)]. norter p	o medical period is l ill not affe at any time	imaging isted beleet the use and rev	ow.  See or disclosure of my prote toke in writing my permissi
Pur If y  Thi Exp and t form protein and t	pose:  At my request  our medical record contains any record I prohibit their release:  I authorize and request their rest is Authorization is valid for up to 12 moiration Date or Event:  that I may refuse to sign this Authorization for purposes of treatment, payments.	rds obtained lease [unles nonths from ation. If I dent or eligible r disclosed the my protection of the control	Other:	eable to r(s)]. norter properties in the content of	o medical period is l ill not affe at any time extent Ho as authori	imaging isted believe the use and revely Cross	ow.  se or disclosure of my prote roke in writing my permissi Health relied on this Authone or permitted by law. Once

<u>For release to the patient</u>, there is a fee based on type of delivery (paper vs electronic). Electronic records sent in electronic format (CD or electronic) - \$6.50. Paper records are charged based on a per page fee. For sending copies of medical records to physicians or other health care providers, there is no fee except for Radiology Film, there is a \$3.00/sheet fee and no charge for CDs. Note: Holy Cross Health has contracted with MRO to handle the release of medical record information.