Authorization to Obtain or Share Medical Information

Patient ID Goes Here

Patient Name: _____
Last First Middle Initial

Phone: _____ Date of Birth (MM/DD/YYYY): _____

I authorize the Rubin Institute for Advanced Orthopedics/LifeBridge Health:

- ❑ To release copies of medical records to:
- ❑ To obtain copies of medical records from:

Name of Doctor, Individual, or Facility: _____

Address: _____
Street City State Zip Code

Phone: _____ Fax: _____

I am requesting medical records from specific dates of service/treatment: _____

The purpose or need for such disclosure is: _____

I am requesting the following types of medical records:*

- ❑ Abstract (summary, op report, paths, consults, H&P, lab work)
- ❑ Doctor's office notes
- ❑ Operative report
- ❑ X-ray, MRI, and CT scans
- ❑ Implant record
- ❑ EKG, EEG, and cardiopulmonary
- ❑ Emergency room record
- ❑ Discharge summary
- ❑ Alcohol, detox, and drug abuse
- ❑ Other: _____

**Please note that medical records to be obtained/released may contain medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, HIV/AIDS testing, HIV/AIDS results, or HIV/AIDS information.*

I authorize the Rubin Institute for Advanced Orthopedics/LifeBridge Health to discuss my personal health information with those designated below:

Name	Relationship	Phone

Signature of Patient, Legal Representative, or Guardian _____ Date/Time _____

Printed Name of Patient, Legal Representative, or Guardian _____

Signature of Witness _____ Date/Time _____

Printed Name of Witness _____

Office Tracking: MR#: _____ **Date Completed:** _____ **Completed by:** _____ **# pages:** _____

This authorization will expire within 1 year unless otherwise indicated. ***Photo ID may be requested at the time of release.*** *The consent to disclose information may be revoked by me at any time in writing except to the extent that action has been taken in reliance thereon, as set forth in the LifeBridge Health Notice of Privacy Practices. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Subsequent re-disclosure or recopying of this information is not authorized without specific consent of the patient or authorized representative as provided in the Annotated Code of the State of Maryland, Article 4-302 (d).*