CAPITAL WOMEN'S CARE
Working Together for Women's Health

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION FROM CAPITAL WOMEN'S CARE

___ I hereby authorize Capital Women's Care (CWC) to use and disclose my individually identifiable Protected HealthInformation (PHI) in the manner described below.

___ I understand that I have the **right to access**[1] my complete medical records maintained by Capital Women's Care, based on the federal HIPAA law. I understand that when I am requesting a copy (electronic or hardcopy) of my records, or wishing to send my records to a third-party, I will be asked to sign this form. I also understand that my PHI may be re-disclosed by the person or entity receiving my PHI from CWC, and that it then may no longer be protected by federal privacy regulations. Maryland law allows for such redisclosure by Capital Women's Care if it is authorized by the person in interest (patient).[2] I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that Capital Women's Care reserves the right according to their HIPAA Practicing Guidelines to use a third-party vendor to process requests for production or to copy medical records containing PHI - information.

TYPE OF INFORMATION TO BE RELEASED/COPIED/PROVIDED BY CAPITAL WOMEN'S CARE:

1. GENERAL RELEASE: I would like to obtain copies of the following:

___ Records in Capital Women's Care's Designated Record Set[3], excluding information the patient does not have a "**Right to Access**" Please Check ONE: **All Dates**: _____ **OR** From: _____ To: _____

___ A Continuity of Care Document (A summary listing which may include active allergies and adverse reactions, current medications, active problems, dates of services, immunizations, social history, last filed vital signs, lab results if applicable)

___ External Records[4] not included in the Capital Women's Care Legal Medical Record (Please specify)

___ Lab Results, X-Ray Reports, Surgical Records, Immunization Records (Please specify)

___ Other, please specify: _____

TYPE OF INFORMATION <u>NOT</u> TO BE RELEASED/COPIED/PROVIDED BY CAPITAL WOMEN'S CARE:

2. CONFIDENTIAL INFORMATION PROTECTED BY STATE/FEDERAL LAW: I would like the following information <u>excluded</u> from the information released:

___ Drug or Alcoholism Abuse Diagnosis/Treatment (specify)

___ Mental Health Diagnosis/Treatment (specify)

___ Sexually Transmitted Disease or AIDS/HIV Diagnosis/Treatment/Counseling (specify) _____

[1] An individual does not have a right to access PHI that is not part of a designated record set because the information is not used to make decisions about individuals. This may include certain quality assessment or improvement records, patient safety activity records, or business planning, development, and management records that are used for business decisions. In addition, two categories of information are expressly excluded from the right of access: Psychotherapy notes, and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. See 45 CFR 164.524(a)(1)(ii).

[2] HEALTH-GENERAL ARTICLE § § 4-301--4-309, 8-601

[3] A "Designated Record Set" is defined by HIPAA as a group of records maintained by a covered entity that may include patient records, bills, information maintained by medical management record systems, or information used to make care-related decisions.

[4] External records include but are not limited to Special Outside Correspondence. Such records are records created by non-Capital Women's Care providers, sent to Capital Women's Care, and added into the patient's electronic health record. This information is supplied to Capital Women's Care but, per our Designated Record Set policy, it is not included in our Legal Medical Record and shall be supplied to patients only upon request.

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PROTECTED HEALTH INFORMATION TO BE RELEASED & METHOD OF RELEASE:

Entity or Patient Name (if requesting own records): _____

Street Address or Fax Number where records are to be sent: _____

City/State/Zip: _____

Purpose for Request: _____

A. Please release my medical records as a Paper/Hard Copy (check here): _____

B. Please release my medical records via fax or electronically saved to Patient Portal, if available (check here): _____

C. Please hold my records and inform me when and where to retrieve them (check here): _____

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that I have read, signed, and received a copy of this authorization upon my request or at the request of a representative legally authorized to make this request on my behalf. I understand that I will be billed for copies of my medical records according to applicable state and federal laws and guidelines. I understand that this request will be valid for ninety (90) days after the date indicated below, unless otherwise noted on this form.

PATIENT INFORMATION

Patient Name (Print): _____

Former Name (if applicable): _____

Telephone Number (Main): _____

Birth Date: _____

Email Address: _____

_____ _____

Signature of Patient/Legal Representative Relationship to Patient, if not signed by Patient

_____

Date

CWC Internal Use Only
Please Attach Invoice When Fulfilling the Request

Total Fee Billed: _____
Date Request was Received: _____
Date Request was Fulfilled (via email, fax, regular mail, or in-person pickup): _____