LIFEBRIDGE HEALTH
CARE BRAVELY

10007

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Bar Coded Patient Label

Location(s) of Care: Hospital/Physician Practice

☐ Carroll Hospital ☐ Grace Medical Center ☐ Levindale
☐ Northwest Hospital ☐ Sinai Hospital
☐ Hospital Outpatient Department:
☒ Physician Practice: Cardiovascular Assoc. of MD

Patient's Name (print) | Phone Number | Patient's Date of Birth

Patient's Street Address | e-mail address

City, State, Zip Code | Purpose of Request: Transition of care

I, the undersigned, hereby authorize _____

☒ to **release** copies of medical records to: Integra Heart - Dr. Amir Najafi

☒ to **obtain** copies of medical records from: Cardiovascular Associates of MD

Date(s) of Service: Last 3 years

Type of records being requested (check all that apply):

☒ Abstract (Summary, Op Report, Paths, Consults, H&P, lab work)
☐ Emergency Room Record
☒ Outpatient Surgery
☐ Discharge Summary
☐ Admission History and Physical
☒ Consultation Report
☐ HIV / AIDS Report
☒ Operative Report / Pathology Report
☐ Alcohol / Detox / Drug Abuse
☒ X-ray, EKG, EEG, Labs, Cardiopulmonary
☐ Physical Therapy / OT / Speech
☒ Nuclear Medicine
☐ Clinic
☒ Doctor's Office Notes
☐ Mental Health / Psychiatry
☐ Bills/Itemized Bills
☒ Other Cardiac Cath and Device Check

Person/Company that you wish to receive your records:

Name: Integra Heart - Dr. Amir Najafi
Address: 2021B Emmorton Road, Suite 110
Bel Air, MD 21015
Phone Number: 410-638-9950
Fax (if applicable): 410-638-9956
e-mail address: N/A

The medical records to be released may contain medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, STD,HIV/AIDS treatment or testing, and/or reproductive health information – including abortion.

Format Requested / Delivery Method

☒ Mail paper records to address listed above
☐ Review or pick up paper records in Health Information management (HIM) Department
☒ Fax to number listed above (health care providers only; no personal faxes)
☐ Other: (describe) _____

Fees: A reasonable cost-based fee may be charged for copies of records being requested. Patients may request a cost estimate from HIM in advance.

☐ Receive electronically via email (check one and print email address)

Signature | **Date** | **Time** | **Relationship to Patient**

Witness | **Date** | **Time** | **Clock #**

This authorization will expire within 1 year unless otherwise indicated. 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)
***Photo ID may be requested at the time of release.**

MR# | Date/Time Completed | Completed By | # pages