HOLY CROSS HEALTH
A Member of Trinity Health

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Printed Patient's Name_____Phone (_____)_____-_____

Patient's Birthdate_____Email Address_____

Address_____ City_____ State_____ Zip_____

DESCRIPTION OF MEDICAL RECORDS REQUESTED

Please select facility from which you are requesting records:

- ☐ Holy Cross Hospital – Silver Spring
- ☐ Holy Cross Hospital – Germantown

Other _____

List Date(s) of Treatment _____

_____

Please select documents to disclose:

☐ Emergency Department Report	☐ Discharge Summary	☐ History and Physical
☐ Consultations	☐ Operative/Procedure Report	☐ Lab/Pathology Results
☐ Progress Notes	☐ Test Results (EKG, EEG, echo)	☐ X-Ray/Diagnostic Results
☐ Summary/Abstract Record Set	Specify Test Result_____	

☐ Clinic/Physician Office Notes Specify Provider Name_____

☐ Other (list) _____

Please include: ☐ Radiology Images/CD ☐ Itemized Billing Records ☐ Complete Medical Record (Fees may apply)

PURPOSE OR NEED FOR THE DISCLOSURE IS:

☐ Continued Medical Care ☐ Insurance/Payment ☐ Legal Reasons ☐ Patient's Own Use

☐ Other (list) _____

PLEASE DISCLOSE REQUESTED RECORDS TO:

I authorize the medical records indicated above to be provided to the following:

☐ Patient/Myself ☐ Parent/Legal Guardian ☐ HIPAA Personal Representative ☐ Other, specify below:

Name_____

Address _____

Phone_____ Fax_____

FORMAT REQUESTED:(check only one option)

☐ Deliver to Patient Portal/MyChart ☐ CD ☐ Paper ☐ Inspect a copy ☐ Email If you choose email, insert email address and choose secured or unsecured below Email address _____

☐ secured/encrypted email (access instructions provided) ☐ unsecured/unencrypted email*

*If you checked "unsecured email" please be aware that sending and receiving your medical record info via unsecured email creates personal risk of interception and potential identity theft. *Please initial if you are requesting unsecured delivery via your personal email listed above. Initials_____

**If records are unable to be emailed due to size limitations, please select an alternate format: ☐ Paper or ☐ CD
**Records provided on CD or Paper will be sent via the United States Postal Service.

Charges for Access: We will not charge you for your first copy of your pertinent record set and/or outpatient diagnostic test results sent to you, the patient's parent or legal guardian, or your HIPAA personal representative. If you ask us to copy your complete medical record, we may charge a reasonable fee as permitted by HIPAA Privacy regulations. Health Information Management utilizes a copy service to complete most record requests. You may be invoiced directly by the copy service where applicable. You may request to be notified of any charges for approval prior to having your records sent to you.

Information About Your Access Rights: Except under limited circumstances, we will provide you with access to your records. We will respond to your request within 30 days (or 60 days if the extra time is needed to gather records) from the time we receive this completed form. In certain situations, we may deny your request but if we do, we will tell you in writing of the reasons for the denial and explain your rights to having the denial reviewed.

I hereby request access to my health information as noted above maintained by Holy Cross Health I understand that the disclosure of my health information MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, treatment for alcohol and/or drug abuse, and/or genetic testing.

Please initial below to authorize the disclosure of any of this information

_____Alcohol/Drug Abuse or Addiction Diagnosis Treatment

_____Behavioral/Mental Health Information

_____Communicable Disease, including Sexually Transmitted Disease

_____HIV/AIDS Related Information, including testing and treatment

_____Genetic Testing

_____Reproductive Records

_____State Specific Regulations to authorize (customize by ministry if applicable)

If I refuse to sign this Authorization the Holy Cross Health will not withhold treatment from me and will not disclose the information to the recipient specified above.

I understand that if the recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by the recipient and no longer protected by these regulations.

I understand that I have the right to revoke this authorization by written notice to the Holy Cross Health listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those prior actions.

This authorization expires on: _____ or upon the following event: _____.
(Date)

(If no date or event is specified, this authorization will expire one (1) year from the date of signature.)

SIGN HERE_____
Signature of Patient, Parent/Legal Guardian, or HIPAA Personal Representative *Date*

Printed name of patient's Parent/Legal Guardian or HIPAA Personal Representative, if applicable _____

Describe Relationship to patient (e.g., minor's parent, guardian)_____

Mail request form to:
Holy Cross Hospital
1500 Forest Glen Rd. Silver Spring, MD 20910

Mail request to:
Holy Cross Germantown Hospital
19801 Observation Dr - Germantown, MD 20876

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request these records. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at Law, etc. HIPAA personal representative is defined as a person with legal authority to make healthcare decisions on behalf of the individual.

HIMROI

Authorization to Use or Disclose PHI

NAME

DOB

MRN