BROOKSIDE HEALTH & WELLNESS
RACHEL FRIEND-LANTZ, CRNP

6500 Thayer Center
Oakland, MD 21550

Office: (301) 334-5610
Fax: (888) 843-8457
info@brooksidehealthandwellness.com

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Complete all sections of this Authorization as appropriate to your request.

**Patient Name:** _____ **Birth Date:** _____
(first) (m. initial) (last)

**Address:** _____ **Phone #:** _____
(street address)

_____ **Date Requested:**
(city) (state) (zip code)

**Please release My Health Information** ☐ **To:** ☐ **From:**

**Brookside Health & Wellness LLC/ Rachel Friend-Lantz, CRNP 6500 Thayer Center Oakland, MD 21550**
**Office: (301) 334-5610**
**Fax: (888) 843-8457**
**Email: info@brooksidehealthandwellness@gmail.com**

☐ Provide a copy of **My Health Information** to me ☐ Let me look at **My Health Information** (I am not requesting a copy)

☐ Release **My Health Information** to: ☐ Discuss **My Health Information** with: ☐ Obtain copies of **My Health Information** from:

_____
_____
_____
_____
Phone/ Fax

**WHAT**

For this Authorization, **"My Health Information"** means (check one or more):

☐ Abstract (discharge summary, operative notes, clinic notes, diagnostic testing)
☐ Billing Record
☐ Diagnostic Test/Results (lab, x-rays and other test results)
☐ Discharge Summary
☐ Emergency Room Record
☐ History & Physical
☐ Immunization Record
☐ Mental Health Records
☐ Operative Report
☐ Outpatient Record
☐ Pathology Report
☐ Progress Note
☐ Other:_____

**ALL RECORDS? YES NO**
**(Circle Option)**

**If I have initialed here (_____), "My Health Information" includes Substance Abuse Records/Information.**

If I have initialed here (_____), this Authorization does NOT include records from other healthcare providers that are a part of my records included in this request. (If this blank is not initialed, those records ***will be*** included.)

For the date(s) of service from: _____ to _____ (records will be provided for all service dates if left blank)
(insert date(s) of service requested)

**WHY**

☐ At my request ☐ For my healthcare / treatment ☐ For legal purposes ☐ For payment / insurance purposes

Other: _____

BROOKSIDE HEALTH & WELLNESS
RACHEL FRIEND-LANTZ, CRNP

**FORMAT:** I request that the copy be provided (where possible/available):

☐ on paper ☐ electronically on CD ☐ Fax ☐ electronically on flash drive

☐ through a web portal, with notice provided to my email account at: _____

☐ by unencrypted e-mail to this email address: _____

☐ ☐ Pick-up ☐1st Class Mail ☐Certified Mail (minimum $IO charge)

**** Please note that Maryland law stipulates the prepaid fees for medical record copying are as follows: A preparation fee of no more than $22.88 (Please note that preparation fees can be charged to hospitals and insurance companies, but NOT patients.), plus a fee of no more than 76 cents per page copied, plus the actual cost of shipping and handling. Reasonable fees may be charged for duplicate x-rays. ****

**Important:** I understand that the CD/disc or flash drive is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. Additionally, I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive **My Health Information** on a CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.

I understand there may be a fee for a copy of My Health Information. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _____. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

**Signature of Patient Only**: _____ **Date**: _____/_____/_____
(Required)

**If you are NOT the patient but are signing on behalf of the patient, please complete below**

**I,** _____, **am the (check which applies)**
(print your name)

- ☐ **Parent with Parental Rights** *(not sufficient for substance abuse records)*
- ☐ **Registered Kinship Care Relative** *(not sufficient for substance abuse records)*
- ☐ **Court Appointed Guardian**
- ☐ **Legally Appointed Healthcare Agent** *(not sufficient for substance abuse records)*
- ☐ **Medical Power of Attorney** *(not sufficient for substance abuse records)*
- ☐ **Power of Attorney with Right to See Medical Records** *(not sufficient for substance abuse records)*
- ☐ **Surrogate Decision Maker** *(not sufficient for substance abuse records or mental health records)*
- ☐ **Court Appointed Personal Representative of Deceased**

**Representative's Signature**: _____ **Date**: _____/_____/_____
(Required)

**Address**: _____ **Phone**: _____

**You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).**



**Date Records Mailed/Picked-up:** _____
**Fees for Copying and Mail:** _____