CalvertHealth Medical Center

CONSENT FOR RELEASE OF INFORMATION

1. I hereby authorize **CalvertHealth Medical Center** to release the following from the health record(s) of:

   Patient Name/Address: _____ Date of Birth: _____

   _____ Medical Record No.: _____

   _____

   Covering the period(s) of hospitalization from: _____ _____ for the purpose of: _____
   Admission Discharge

2. Information to be released:

General Medical Records	**Psychiatric Medical Records** ____Records/info sent ____Records/info not sent
_____ Complete Records	
_____ Abstract of Record to include DS, H&P, OP, Path, Lab, X-ray	_____ Phone contact made _____ By Whom: _____ Date
_____ History and Physical	_____ Psychological Assessment
_____ Operative Report/Path Report	_____ Psychological History and Physical
_____ Discharge Summary	_____ Psychiatric Discharge Summary
_____ Test results	_____ Letter to:
_____ Other, specify	_____ Other, specify
_____	_____

3. Information released to: (Name/Address) _____ Phone Number: _____

   _____

   _____

4. Authorization is valid until: _____. **This period may not exceed one (1) year**. If left blank, authorization is valid for 3 months.

5. I understand this consent may be revoked, in writing only, at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

6. The facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

7. I acknowledge that the medical records that I authorize for release may contain information relating to my HIV status and/or information related to drug and alcohol diagnosis and/or treatment.

Signed: _____ _____ INFORMATION RELEASED:
Patient or Representative Relationship to Patient

_____ _____
Witness Date/Time

AUC.REL