Falls Medical Specialists, LLC

10753 Falls Road, Suite 225
Lutherville, MD 21093
P: (410) 583-2828 F: (410) 583-2841

Authorization of Disclosure for Protected Health Information

Patient Name:_____ DOB:_____ SSN (Last 4): _____

FMS is authorized to: ◯ **Send Records To** ◯ **Receive Records From** ◯ **Openly Communicate With**

Name or Facility:_____ Address:_____

City:_____ State:_____ Zip Code: _____

Phone Number:_____ Fax Number:_____

Information to be Disclosed:

- ◯ Entire Record
- ◯ Evaluation
- ◯ Treatment Plan
- ◯ Progress Notes
- ◯ Discharge Summary
- ◯ Medications
- ◯ Lab Results
- ◯ Letters/Paperwork
- ◯ Appointment Information
- ◯ Other: _____

Purpose of Disclosure:

- ◯ Continuity of Care
- ◯ Disability Determination
- ◯ Legal Proceedings
- ◯ At Patient's Request
- ◯ Other _____

Please Release: ◯ ***Verbal and Written Information*** ◯ ***Verbal Information Only*** ◉ ***Written Information Only***

READ CAREFULLY

My signature below acknowledges my understanding of the following:

1. I understand that medical/behavioral health records are confidential. By signing this authorization, I am allowing the release of information, including any substance abuse information, to the agency or person specified above. Transfer of the information released above to persons or agencies not specified is prohibited by law.
2. I understand that signing this authorization is not a condition of receiving treatment here.
3. This authorization includes both information presently compiled and information to be compiled during the course of the client's treatment at this agency.
4. I understand that there is a potential for the information disclosed to be subject to re-disclosure by the recipient and no longer protected by this law.
5. This consent is subject to revocation by the undersigned at any time by completing the notice of revocation at the bottom of the page.
6. This consent to release information (unless revoked earlier) will automatically terminate one year from the date of signing, or twelve months from the date of signing if the purpose is for other than treatment.
7. Specify any special conditions, date, events that would result in revocation: _____
8. I understand that I have the right to receive a copy of this authorization and to request to see or copy the information disclosed.
9. This authorization to release information is subject to the following restrictions: _____

Patient's Signature_____ Date _____

Parent or Guardian Signature if Patient a Minor _____

NOTICE OF REVOCATION: THIS REVOCATION CANCELS MY AUTHORIZATION ABOVE:

Patient/Guardian Signature_____ Date _____