

# 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): \_\_\_\_\_

<b>FMS is authorized to:</b> <input type="radio"/> <b>Send Records To</b> <input type="radio"/> <b>Receive Records From</b> <input type="radio"/> <b>Openly Communicate With</b>		
Name or Facility: _____	Address: _____	
City: _____	State: _____	Zip Code: _____
Phone Number: _____	Fax Number: _____	

### Information to be Disclosed:

- |   |   |
|---|---|
| <input type="radio"/> Entire Record     | <input type="radio"/> Medications             |
| <input type="radio"/> Evaluation        | <input type="radio"/> Lab Results             |
| <input type="radio"/> Treatment Plan    | <input type="radio"/> Letters/Paperwork       |
| <input type="radio"/> Progress Notes    | <input type="radio"/> Appointment Information |
| <input type="radio"/> Discharge Summary | <input type="radio"/> Other: _____            |

### Purpose of Disclosure:

- |  |
|--|
| <input type="radio"/> Continuity of Care       |
| <input type="radio"/> Disability Determination |
| <input type="radio"/> Legal Proceedings        |
| <input type="radio"/> At Patient's Request     |
| <input type="radio"/> 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 \_\_\_\_\_