Authorization for Release of Health Information
Complete all sections of this authorization as appropriate to your request

Patient Name	
Date of Birth	
Address	
City, State, Zip	
Phone #	

WHO
I hereby authorize West Cecil Health Center (WCHC) to take the following action:

ACTION REQUESTED (CHECK ONE)
- ☐ 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:

Name of Person or Entity	
Address	
City, State, Zip	
Phone #	
Fax #	

WHAT
For this authorization, "My Health Information" means:

☐ Medical Records	☐ Dental Records
☐ Mental Health Records (Protected Psychotherapy notes not included)	☐ Substance Abuse Records
☐ Labs	☐ Imaging Studies
☐ Other (Specify)	

I authorize WCHC to disclose My Health Information **EXCEPT** the following:
- ☐ Mental Health Records
- ☐ Substance Abuse Records
- ☐ Genetic Information
- ☐ Communicable Diseases including, but not limited to, HIV, AIDS, and STDs
- ☐ Records from other healthcare providers that are part of my WCHC record
- ☐ Other (Specify) ____

For date(s) of service from _________________ to _________________ (records will be provided for all service dates if blank)

WHY

☐ At my request	☐ For my healthcare/treatment
☐ For legal purposes	☐ For payment/insurance purposes
☐ Other (Specify):	

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

- ☐ On paper
- ☐ Through the web portal
- ☐ By encrypted e-mail at this address: ____
- ☐ By unencrypted e-mail at this address: ____
- ☐ By other electronic means (if agreed upon by WCHC): _____________________________

Important: I understand that unencrypted e-mail, CDs, and flash drives are not password protected and that is my responsibility to take extra precautions to protect the data on the device. I understand that unencrypted e-mail could be intercepted and seen by others; in addition, I understand that there are risks including misaddressed/misdirected messages; shared e-mail accounts; and messages forwarded to others. I am acknowledging and accepting these risks.

I understand that WCHC has up to 21 days to release my record and will communicate with me if there are any reasons for delay. I understand there may be a fee for a copy of My Health Information. I understand that all fees are reasonable and set in compliance with applicable law. I agree to pay this fee.

FEES:

Publishing information to the portal: No charge
Electronic transmissions: $6.50 flat fee
Paper Copies: $22.88 preparation fee plus $0.76/page fee and postage

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 90 days from the 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 the action has been taken prior to the 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.
- WCHC will deny a request for records if information was obtained from another health care provider under a promise of confidentiality or if information compiled is reasonably anticipated for use in a civil, criminal, or administrative action or proceeding.
- WCHC may deny a request for records if the information, if in the exercise of professional judgment, is reasonably likely to cause substantial harm to such other person.

Signature of Patient ONLY: _______________________________________Date: _____________

If you are NOT the patient but are signing on behalf of the patient, please complete below and you must provide proof of your authority to act on behalf of the patient with exception to a parent:

I am the (check which applies):

- ☐ Parent with parental rights (not sufficient for substance abuse records)
- ☐ Registered kindship 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 or mental health records)
- ☐ Court appointed personal representative of deceased

Name of Person or Entity	
Signature	
Date	
Address	
City, State, Zip	
Phone #	