CHI HEALTH CARE
formerly Casey Health Institute

Authorization for Disclosure and Release of Medical and Mental Health Information

Name: _____ D.O.B.: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip code: _____

I hereby authorize, the release of my medical or mental health information from/to the following parties:

FROM: Name of person or facility: _____

☐ **CHI Health Care** 15001 Shady Grove Rd suite 200 Rockville MD, 20850 **Fax:** 301-963-0072
Address: _____
Phone: _____ Fax: _____

TO: Name of person or facility: _____

☐ **CHI Health Care** 15001 Shady Grove Rd suite 200 Rockville MD, 20850 **Fax**: 301-963-0072
Address: _____
Phone: _____ Fax: _____

Type of disclosure: ☐ Verbal ☐ Copies of record
The purpose of this disclosure is for:

☐ Ongoing treatment ☐ Employment ☐ School ☐ Legal ☐ Personal use ☐ Other

Delivery Method: ***encrypted email*** **or USB drive only** *(Note: Most records are available to you free on our Patient Portal, see front desk for instructions)* **Page print outs will not exceed 150 pages upon request.**

By INITIALING below, I am authorizing the release and/or receipt of the following information:
_____ All medical services information and complete medical records
_____ All mental health counseling information (*Subject to MD's Confidentiality of Medical Records Act)*

Consult reports	_____ All	**OR**	_____ from _____	to	_____
Labs results	_____ All	**OR**	_____ from _____	to	_____
Radiology reports	_____ All	**OR**	_____ from _____	to	_____
Vaccine records	_____ All				

Please indicate type(s) of Information, if not specified above (e.g. Summary Report, Attendance Verification):
_____

All information regarding Alcohol and/or Drug Abuse (42 C.F.R. 2.34 and 2.35) or HIV/AIDS [Health and Safety Codes 120980(g)] will be released **unless you restrict it by INITIALING here:** _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is 1 year from today's date.
- I understand that I may revoke this authorization at any time and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that if I have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality law.
- I understand that CHI Health Care will not release any records from a third party (i.e. hospital records, specialist).

_____ _____
Signature Date