RUSSELL ROTHENBERG, MD
RRRothenberg@Gmail.com

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR § 164.508 and the Annotated Code of Maryland, Title 10 Health General Article §§ 4-301 – 4-307.

All items on this authorization must be completed in full, or the request will not be honored.

I hereby authorize Russell Rothenberg, MD to release the protected health information of:

PATIENT: _____DATE OF

BIRTH: _____PHONE #:_____

ADDRESS: _____

The information is to be released to:

NAME:_____ADDRESS: _____

PHONE #:_____

The information I wish to have released is _____(include dates of service):

Discharge summary ___
History and physical exam ___
Consultation reports ___
Reports of operations ___
Other___

Imaging reports ___
Diagnostic cardiology reports ___
Laboratory reports ___

I do _____ I do not _____wish to have information about HIV/AIDS released under this authorization.

I do _____ I do not _____wish to have mental health records released under this authorization.

I do _____ I do not _____wish to have information about drug/alcohol abuse treatment released under this authorization.

If Russell Rothenberg, MD is in possession of records from another provider, I do _____ I do not ___wish to have those records released under this authorization.

Please complete both sides of this form

MEDICAL RECORDS ARE BEING RELEASED FOR THE PURPOSE OF:

_____

ANY DISCLOSURE RESTRICTIONS Yes____No____

If yes, please explain _____

We will consider your request seriously but as per the Federal Privacy Standards, we are not obligated to carry out your request.

This authorization will expire one year from the date it is signed unless a shorter time is indicated here:_____

I understand:

- This authorization is voluntary.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke the authorization, I understand that I must notify Russell Rothenberg, MD in writing.
- I understand that once information covered by this authorization has been disclosed redisclosure of the information by that recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by Maryland law.

_____ _____

Patient or Personal Representative's Signature Date

If signature is other than patient, explain your authority to act for the patient:

_____

_____ _____

Witness Date

If there is a question or concern with responding to this authorization, you will be contacted by Dr. Rothenberg. Questions or complaints about the federal privacy regulations or policies and procedures relating to these federal regulations should be directed to the Randi Kopf, RN, MS, JD at Kopf@KopfHealthLaw.com.

DATE RECORDS REQUIRED BY: _____

REQUEST RECEIVED BY: _____ DATE: _____

DOCUMENTS SENT BY: _____ DATE: _____