Chase Brexton Health Care
Because everyone's health matters.

RELEASE OF INFORMATION (ROI) TO SEND AND/OR OBTAIN RECORDS

Phone: 410-837-2050 **Fax:** 866-629-0091

I authorize Chase Brexton Health Services, Inc. ("Chase Brexton Health Care") to disclose and/or obtain my individually identifiable health information, as described below.

Patient Information:

Patient Legal Name: ______________________________ DOB: ______________

Name preference (How would you like to be addressed?): ______________ Phone: ______________

Please send my health records to or obtain my health records from the following office:

Name: ______________________________

Address: ______________________________

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Phone: ______________________ / Fax: ______________________

Medical (check all that apply)

Send	Obtain	
☐	☐	All
☐	☐	Hospital Notes
☐	☐	Operative/Pathology Notes
☐	☐	Consult Notes
☐	☐	Laboratory Results
☐	☐	HIV/AIDS
☐	☐	Imaging/Diagnostic
☐	☐	Other ______________

☐ Send and Obtain ALL medical records

Behavioral Health

Send	Obtain	
☐	☐	All
☐	☐	Mental Health
☐	☐	Other ______________

☐ Send and Obtain ALL behavioral health records

Pharmacy

Send	Obtain	
☐	☐	All
☐	☐	Other ______________

☐ Send and Obtain ALL pharmacy records

Please release the above records dated ____________ to ____________

Please indicate "Attention to: ______________________" (if applicable)

I understand that:

1. This HIPAA authorization for use and disclosure of information form is voluntary;
2. My treatment and the payment for my treatment will not be affected by my signing or not signing;
3. I may revoke this authorization at any time by notifying Chase Brexton in writing, but the revocation will not apply to information that has already been disclosed;
4. The information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected; and
5. I may request a copy of this authorization.

This ROI expires within 1 year, or when it is used for its single purpose, whichever comes first.

Signature of Patient or Patient's Legal Representative: ______________________ Date: ____________

Printed Name of Legal Representative (if applicable): ______________________

CHASE BREXTON USE ONLY: I provided records on ______________________ (date) via

[ ] Mail [ ] Fax [ ] Handed to recipient

Employee Name: ______________________ Date: ______________________