

Name of Clinic  
Address  
Phone

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize the \_\_\_\_\_ of the Baltimore City Health Department ("BCHD")  
to use, or to disclose to

\_\_\_\_\_  
\_\_\_\_\_.

*(If the information will be disclosed, list the agency, organization, person, or class of persons to whom the disclosure can be made.)*

the following health information:

- Complete record
- Diagnostic Test/Results (labs, x-rays, other test results)
- Mental Health Records
- Immunization Record
- Other: \_\_\_\_\_

For the date(s) of service starting: \_\_\_\_\_

*(Insert date(s) of service requested.)*

\_\_\_\_\_ may use or disclose the health information described above for the  
following purposes:

\_\_\_\_\_  
\_\_\_\_\_.

*(List the reasons for the use or disclosure. If the use or disclosure is being made at your request, you may simply state, "at my request.")*

I understand there is a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland State law. By signing this authorization, I agree to pay these fees at the time this request is made.

This authorization is valid for one year from date signed. I understand that I can revoke this authorization in writing at anytime. The revocation will become effective when it is received by BCHD at the following address: Baltimore City Health Department, Attn: Laura Herrera, M.D., 210 Guilford Avenue Baltimore, MD 21202.

However, the revocation will not be effective to the extent that \_\_\_\_\_ already has used or disclosed my protected health information in reliance on this authorization.

I understand that once \_\_\_\_\_ discloses information under this authorization, it is possible that the information will be subject to re-disclosure by the recipient and no longer protected by federal medical privacy law.

I understand that \_\_\_\_\_ may not require me to provide this authorization in order for me to obtain treatment, payment, enrollment, or eligibility for benefits.

\_\_\_\_\_  
Print Name of Signing Party

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
If you are signing this authorization on behalf of someone other than yourself, state your authority to act for that person. For example, state if you are the person's parent, guardian, conservator, or legally authorized representative.