ROYAL BEHAVIORAL
HEALTH SERVICES LLC
Phone: 4107775097
FAX:4107778495

Medical Records Release Form

Authorization to Obtain or Disclose My Health Care Information Email:_____

Patient Name:_____ Date of Birth: _____

Previous Name: _____ Daytime Phone: _____

I request and authorize:

Name _____ _____

Address _____ _____

City: _____ State:_____Zip Code: _____

Phone:_____Fax: _____

To release healthcare information of the patient named above to:

ROYAL BEHAVIORAL
HEALTH SERVICES

Phone:
410-777-5097

This request and authorization apply to:

All healthcare information including labs, imaging, and hospitalization.

I understand that my medical record may include information on the diagnosis/treatment related to psychiatric, psychological or mental conditions, drug and or alcohol use or abuse, sexually transmitted diseases (STD), acquired immune deficiency syndrome (AIDS), and or HIV status and genetic testing.

Patient may revoke this authorization at any time prior to expiration by notifying in writing.

The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by federal law. State and federal law specifically requires that any patient medical record and/or personal health care information containing drug and alcohol diagnosis and treatment, mental health and sexually transmitted diseases, including HIV/AIDS are privileged and confidential and may only be disclosed by express authorization, except as required by law. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may refuse to sign this authorization. The releasor or releasee may not condition treatment, payment, enrollment or eligibility on the authorization of this release.

Patient Name: (please print)_____Relationship to patient (if not self) _____

Patient signature (or Responsible Party):_____Date: _____