XXX-XX-_ _ _ _

Signature on File for Medical Release Form

I, _____ give UM Pulmonary Care and Sleep Medicine permission to request and receive my medical records from any and all previous and current physicians and/or medical facilities. These records include but are not limited to:

- ☐ Office notes
- ☐ Radiology
- ☐ Bloodwork
- ☐ Hospital Records
- ☐ Demographics
- ☐ Insurance
- ☐ Diagnostic testing
- ☐ Other _____

The signature below is valid as long as this patient is under the care of UM Pulmonary Care and Sleep Medicine.

_____ _____

Patient Name PRINTED DOB

_____ _____

Patient Signature Date

If you have any questions please feel free to contact us at **(410) 832-3400**.

Thank you,

UM Pulmonary Care and Sleep Medicine Team

Please complete this form before your appointment and bring it with you:

Name: _____ DOB: _____

Retail Pharmacy: _____

Address: _____

_____

Phone #: _____

Fax#: _____

Mail Away Pharmacy: _____

Address: _____

_____

Phone #: _____

Fax#: _____

If you have any questions please feel free to contact us at **(410) 832-3400**.

Thank you,

UM Pulmonary Care and Sleep Medicine Team

PCCAB
pulmonary and critical care associates of baltimore

Authorization for Release of Medical Records

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. The General Authorization for Release of Medical Records that you sign authorizes Pulmonary and Critical Care Associates of Baltimore P.A. (PCCAB) to disclose the information in your medical records to the extent needed for the following purposes:

1. For the purpose of providing treatment to you. This would include, for example sharing information with employees and contractors of PCCAB, or with other health care providers who are treating you or consulting in your care.
2. For the purpose of arranging payment for your care. This would include, for example, your insurer or other third-party payor who is responsible for paying all or part of the cost of your care.
3. For the purpose of PCCAB's "health care operations." This would include such things as internal quality assessment activities, contacting other healthcare providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer services, resolutions of internal grievances and the provision of legal and auditing services.

B. A Specific Authorization for Release of Medical Records that you may sign authorizes PCCAB to make a specific disclosure that is not covered under section A, above. A specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations on the authority to disclose your records.

C. You may revoke any authorization provided to PCCAB by giving PCCAB a written notice of revocation. PCCAB may refuse to treat you if you revoke the General Authorization.

D. PCCAB may be required by law to make disclosures of your records that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.

E. PCCAB may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

F. You have the following rights with respect to your medical records/information:

1. You have the right to request restrictions on the use and disclosure of your medical records/information; however PCCAB is not required to agree to restrictions not guaranteed by law. You will be informed if PCCAB will not agree to a requested restriction.

2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.

3. You have the right to inspect and copy your medical records (PCCAB is entitled to charge you a reasonable fee related to the cost of copying your records).

4. You have the right to seek to amend your medical records, and if PCCAB does not agree with your request, to note your objection in the medical record.

5. You have a right to receive an accounting (list) of disclosures of your medical records/information made by PCCAB. (Except for the disclosures that fall within the scope of PCCAB's "healthcare operations" or disclosures for payment or treatment purpose.)

6. You have the right to receive a paper copy of this notice.

G. PCCAB is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate.

H. If a patient believes that his or her privacy rights have been violated, he patient may complain to PCCAB, or to the Secretary of the U.S. Department of Health and Human Services. To complain to PCCAB, please write or call us with details. PCCAB will not retaliate in any way against a patient for making a complaint.

I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated **Privacy Complaints Contact Person**, Jennifer Pemberton at (410) 832-3400 or mail correspondence to 501 Fairmount Avenue, Suite 103, Baltimore, MD 21286.

J. PCCAB reserves the right to change its privacy practices, and to make its new policies effective for all protected health information that PCCAB maintains. If such changes are made, PCCAB will issue an updated "Notice to Patients" to all PCCAB's patients.

Please acknowledge receipt and review of this information by signing below. For further information, please call Jennifer Pemberton, at (410) 832-3400.

_____ _____

*Patient Name (Printed) *Date

_____

*Date of Birth

_____

*Signature of Patient /Lawfully Authorized Representative

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Request for Disclosure of Medical Information

I _____, give full consent for the below named person/people to discuss any and all medical information with UM Pulmonary Care and Sleep Medicine.

	Name	Relationship	Phone #
1	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

_____ _____

(Patient's Signature) (Date)

_____ _____

(Verified By Office Staff) (Date)

Advance Care Planning Questionnaire

Name:_____ **DOB:**_____ **Today's Date:**_____

To our patients over the age of 65, please check all that apply:

☐ I will provide a copy of my Advanced Care Plan today.

☐ I wish to discuss Advance Care Planning with my provider today

☐ I do not wish to discuss Advance Care Planning with my provider today

(Office staff, please scan into patient's chart)