State of Maryland
Employee Benefits Division
HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested.

Section I

I, _____, give my permission for _____ to share the information listed in **Section II** of this document with the person(s) or organization(s) I have specified in **Section IV** of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

- ☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.
- ☐ Except for the following information:
  - ☐ Mental health records
  - ☐ Communicable diseases including, but not limited to, HIV and AIDS
  - ☐ Alcohol/drug abuse treatment records
  - ☐ Genetic information
  - ☐ Other (specify): _____

Form of Disclosure:

- ☐ Electronic copy or access via a web-based portal
- ☐ Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write “at my request.”

_____

_____

_____

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Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in **Section II** of this document to be shared with the following individual(s) or organization(s):

Name: _____ Organization: _____

Address: _____

Name: _____ Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid (Please choose one of the following):

- ☐ From: _____ To: _____
- ☐ All past, present, and future periods
- ☐ The date of the signature in Section VI until the following event:

_____

I understand that:

- I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing
- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I do not need to give any further permission for the information detailed in **Section II** to be shared with the person(s) or organization(s) listed in **Section IV**.
- Failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act on the individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Signature of Legal Representative: _____ Date: _____

Name of Legal Representative completing this form: _____

If this authorization is being requested/signed by the Legal Representative, you must furnish a copy of the Power of Attorney or other relevant documents designating you as the representative of the member.

State of Maryland - Employee Benefits Division
301 W. Preston Street; Room 510
Baltimore, MD 21201

OR

Via Email: EBD.mail@Maryland.gov
Via FAX: 410.333.7104