UMBC Sports Medicine 1000 Hilltop Circle Baltimore, Md. 21250
CONSENT FOR RELEASE OF INFORMATION

I _____ _____ _____
(Print Name of Patient) *(Birth Date)* *(Social Security Number)*

hereby authorize UMBC Sports Medicine Staff to release any information concerning my medical status, medical condition, injuries, prognosis, diagnosis and related personally identifiable health information to the following person(s) and or agency listed below for the purpose of providing medical care.

I also authorize the person/ agency listed below to disclose PHI to the UMBC Sports Medicine Staff including diagnostic impressions, testing, treatment history, discharge summaries, medical bills and explanation of benefits for the purposes of providing medical care and payment of medical bills.

Medical Providers, Health Insurance & Billing Agents

____ Curtis National Hand Associates **____Union Memorial Sports Medicine** **____UMBC Health Services**
▪ *Dr. Hugh Baugher* ▪*Dr. Andy Tucker*

Radiology (X-ray, MRI, Bone scan, CT)
____ American Radiology ____ Seton Imaging ____ Advanced Radiology ____U of MD Diag. Imaging
____ Other_____

Hospitals
____St. Agnes Hospital ____GBMC Hospital ____St. Joseph Hospital ____Union Memorial Hospital
____UM Medical Center ____Mercy Medical Center____Kernan Hospital ____ Other_____

Surgical Affiliates
____Parkway Pain Anes _____York Rd Anesthesia ____Towson Health Express
____Greater Chesapeake Surgery Center _____ Other_____

Laboratory Services
____LabCorp ____Quest Diagnostic _____UM Pathology Associates

Specialist
____ Baltimore Emergency Services (St Agnes ER) ____UM Eye Associates ____ UM Otology ENT
____ Dr. Applefeld (Cardio) ____ Dr. Gelin (podiatrist) ____ Physiotherapy Associates
____ Dr Hippolito (Dentist) ____ DJ Ortho (bracing) ____ Yalich Clinic
▪ *Dr Nevin Markel, Chiropracort*
____ Other _____

Medical Collection Agencies
____NCO ____ROI ____Other_____

Health Insurance Company
_____ Secondary Insurance Policy. _____HTH Worldwide Insurance _____Policyholder _____

Person/Agency _____ Phone _____
Address _____ Fax _____
City, State, Zip _____

This authorization for disclosure is effective on _____ and expires on _____ (1 year), and may be withdrawn in writing at any time except to the extent that action on this authorization has not already occurred.

last updated 5/26/09

_____ _____

Signature of Patient or Witness
Signature of Parent/Legal Guardian (if under 18 yrs of age)