Please complete this form, sign it, and return to Bloom:
Main Phone: (667) 668-2566
Medical Records: (410) 424-5980
Fax: (240) 317-7626
Email: medicalrecords@bloomhealthcenters.com

*Completion of medical record requests may take up to 30 days, as permitted by HIPAA.

RELEASE OF INFORMATION FORM

Use this form to request Bloom Health Centers to disclose your protected health information (PHI) or medical records to yourself, another person, or another entity.

Patient Details

Patient Name: _____ Date Of Birth: _____

Address: _____ State: _____ Zip Code: _____

Email Address (if applicable): _____

Parent or Legal Guardian of Patient (if applicable)

Name: _____ Date Of Birth: _____

Address: _____ State: _____ Zip Code: _____

Email Address (if applicable): _____

Person or Entity to Release/Obtain Protected Health Information

(If you are requesting your records to be sent directly to you, please provide your information below.)

This information should be (**CHECK ONE ONLY**): ◯ **RELEASED TO** ◯ **OBTAINED FROM**

Name: _____

Address: _____ State: _____ Zip Code: _____

Email Address (if applicable): _____

**If sent via email, recipient will receive a link via email to download files from Bloom's secure system.*

Methods of PHI Transmission

◯ Email. You have the right to receive your information in the format you prefer, including via unencrypted email. Unencrypted email may present risks that others can read without your permission once it leaves our system. We can no longer secure information once it is sent or received. **If you still wish to receive your records via unencrypted email**, **initial here :** _____

◯ Physical copies mailed to the address listed above.

◯ Physical copies picked up from the listed Bloom Location: _____

◯ Other: _____

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Protected Health Information (PHI) to be released

I authorize the following information to be released (choose one):

◯ The complete health record, including patient histories, progress notes, test results, referrals, consultations, insurance records, and the sensitive information listed below, for all dates of service.	◯ The complete health record, including patient histories, progress notes, test results, referrals, consultations, insurance records, and the sensitive information listed below, for the specified date range only: Start Date: _____ End Date: _____	◯ Other (please specify): _____ _____ _____ _____ _____

For the purpose of:

◯ Coordination of care ◯ Continuing care ◯ Evaluation
◯ At the request of the individual ◯ Background information

Sensitive Information

Choose any sensitive information that you **do not** wish to be released:

◯ Substance Abuse, diagnosis or treatment
◯ Billing, Scheduling, and Attendance Information
◯ Medications
◯ Psychological evaluation and reports
◯ Evaluation/Progress notes

Acknowledgment of Rights

I understand the following:

1. **Revocation Rights**: I have the right to revoke this authorization at any time by providing a written request to Bloom Health Centers. Revocation will not apply to information already disclosed under this authorization.
2. **No Conditions**: I am not required to sign this form to receive treatment, payment, or eligibility for benefits.
3. **Redisclosure Prohibition**: The information disclosed under this authorization is protected by federal confidentiality rules (42 CFR Part 2). These rules prohibit the recipient from making any further disclosures unless I provide additional written consent or unless otherwise permitted by law.
4. **Scope of Authorization**: This authorization specifically applies to disclosures for continuity of care purposes with the specified provider(s) listed above.
5. **Expiration date:** This authorization expires one year from the date of signature.

Signature: _____ **Date:** _____

Printed Name / Legal Guardian: _____