Welcome to the Cochlear Implant Center

Greater Baltimore Medical Center (GBMC) Health Partners welcomes you to our practice. We are dedicated to providing you with the kind of care that we would want for our own loved ones.

This Welcome packet is designed to help you understand the options for improved quality care that are available to you, as well as some expectations we have for you to assist us in your care. We look forward to seeing you ***15-minutes*** prior to your scheduled appointment. To save time on the day of the appointment, please read and sign this Welcome packet and complete the enclosed registration forms. Please bring all paperwork with you to your visit along with your insurance card, photo ID, and if applicable, prescription/pharmacy card and any legal documents regarding Healthcare or Medical Power of Attorney, guardianship, custody, or Advance Directives.

Appointments

Please arrive at least 15-minutes prior to all appointments. (For New Patients please arrive with the completed Welcome packet in hand if not completed electronically). We will do our best to see you at the appointed time and/or advise you of any delays. If you arrive past your scheduled appointment time or without your completed Welcome or Registration packet, you may be asked to reschedule your appointment.

If you need to cancel or reschedule an appointment, please contact the practice, and provide at least 24-hour notice of your cancelation. For established patients, if you have canceled less than 24-hours of appointment time a total of three appointments within twelve rolling months, you may be discharged from our practice. For new patients, if you have canceled less than 24-hours of appointment time a total of three appointments within six months, you will not be rescheduled.

Missed Appointments

We reserve the right to charge for missed appointments. This charge will be your responsibility and will be billed directly to you. For established patients, if you have missed a total of 3 appointments within twelve rolling months, you may be discharged from our practice. For new patients, if you have missed a total of two appointments within six months, you will not be rescheduled.

Patient and Visitor Code of Conduct

Please be aware that GBMC has a Zero Tolerance Policy for abusive or violent language and/or behavior directed at our staff, patients, or visitors. Violators may be escorted out of the Practice and may be subject to discharge from GBMC, or other possible legal action.

After-hours needs

If there is an urgent need outside of normal business hours, please call our practice and you will be directed to the on-call provider. Medication requests may not be refilled by the on-call provider.

Medications

At the time of your appointment, we will need to know all the medications that you are currently taking, including prescribed medications, over the counter medications, and vitamins/herbal supplements. Please bring your medications with you to your appointment. Medication refill requests may take up to 3 business days to process. There is a possibility medication refill requests may not be filled on the weekend. Prior authorization may take longer, based on the patient's insurance.

Screenings

Your provider may conduct clinically appropriate screenings, based on evidence-based practices, which will be billed to your insurance. If you do not wish to be screened, please let your provider know.

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that GBMC provide you with information about how we may use your Protected Health Information (PHI). That information is contained in GBMC's Notice of Privacy Practices which you will receive separately. The Notice will tell you:

- How GBMC may use and disclose your protected health information.
- Your rights with respect to the information and how you may exercise these rights.
- GBMC's legal duties with respect to the information.
- Whom you can contact for further information about GBMC's privacy policies.

Patient Contact (Emergency Contact)

The patient contact, also known as an emergency contact, is a local contact we may contact in the event of an emergency. This contact does not have access to your medical records, decision making, or billing records.

Designated Contact

Due to HIPAA Privacy Rules, providers generally may not release your health information to anyone without your permission. This includes family members or friends that you may want the provider to keep informed. You may consent to us sharing information with specific individuals by completing and signing the enclosed Consent to Share Protected Health Information with Designated Contacts. This form must be completed annually unless updates are required.

Health Care Decision Maker

If a patient is a minor or an adult without capacity to consent to their own care, there must be a Health Care Decision Maker who will consent to treatment. For adults who become incapacitated without documents on file, we will refer to Maryland state surrogacy laws to determine your surrogate. We recommend you complete and sign the enclosed Health Care Agent form to communicate your wishes in

the event you cannot speak for yourself. All signed legal documents pertaining to this relationship must be presented to the practice and will be included in your medical record. Documents may include Healthcare or Medical Power of Attorney, Health Care Agent, Legal Guardianship, Custody documents (both joint and sole custody), or an Advanced Directive.

Health Care Directives

To best care for you and respect your long-term wishes, all documents regarding your health care wishes must be presented to the practice and will be included in your medical record. These documents include Advance Directives/Living Will, 5 Wishes, and MOLST orders.

Medical Records

Your medical records will be provided to you, your providers, and your insurance carrier at no charge. If medical records are requested by other parties, such as attorneys, a service charge will be applied for copy and mailing fees. Medical Records requests are not processed in our practice. Contact GBMC's Release of Information department by phone 443-849-2274, fax 443-849-3223, or email medicalrecordsrequest@gbmc.org.

Forms Completion

We reserve the right to charge a fee for completion of forms (Jury duty, Disability, FMLA, MVA, school, camp). Form processing may take 10 business days. Form Fee: $20/form. Expedited fee will be an additional $25 ($45.00/form for completion within 3 business days, weekends are not included).

MyChart at GBMC

MyChart at GBMC is an internet and mobile application that allows patients to view their medical record, receive certain laboratory and imaging results, request prescriptions, pay bills, communicate with their GBMC healthcare providers on non-urgent matters and arrange for clinical services/appointments. You may also use MyChart to share your information with others, including granting continued access to your MyChart account to a friend or family member. To learn more about GBMC MyChart and sign-up for an account, please visit www.gbmc.org/MyChart.

Surveys

Periodically, you may receive surveys online or through the mail asking you to give us feedback about how well we are meeting your needs. We would greatly appreciate your input, as that helps us to improve our service.

Telehealth Visits:

During the COVID-19 pandemic, public health emergency (PHE) declarations at the federal level and in many states made it possible for patients to have appointments with their medical providers remotely

via computer, tablet, or smartphone using different platforms like FaceTime or Zoom. Known as "telehealth," this practice helped people to get medical care and be isolated from others the same time.

With the PHE declarations due to COVID-19 ending, the rules for telehealth are changing back to what they were before the pandemic. GBMC HealthCare providers can no longer deliver telehealth services to a patient who is physically located outside the state of Maryland.

GBMC HealthCare does continue to offer telehealth appointments, but only to **patients physically located in Maryland at the time of the service**. Patients who are not physically located in Maryland at the time of the appointment will need to reschedule their visit.

Additionally, federal privacy rules require that services be provided using secure platforms that protect the medical information you share. For this reason, **all telehealth appointments must be held within GBMC's patient portal, MyChart.** This is also due to the PHE declaration ending, and certain waivers of privacy rules with it. We understand this may pose some challenges and assure you that our staff members are committed to helping patients navigate their telehealth appointments.

Financial Policy

GBMC is committed to providing you with quality and affordable health care. We participate with most insurance plans. We also recognize our obligation to the community to provide appropriate medical care, regardless of ability to pay. We will assist you, if needed, through negotiated payment plans and our Financial Assistance policy. If you have a question about a statement you receive in the mail, please call 1-888-571-2113. Other questions may be directed to 443-849-2450. You can also apply for Financial Assistance through your MyChart account.

Definitions:

CO-PAYMENT is a fixed amount set by the insurer that the patient is responsible for paying at the time of service. The co-payment may vary by the type of service, the provider rendering the service, and/or the place in which the service is rendered.

CO-INSURANCE is the patient's cost share, usually calculated as a percentage of the cost of the service. The co-insurance may not be subject to a deductible amount.

DEDUCTIBLE is the amount the patient is responsible for before the insurance plan starts paying for services. The deductible may not apply to all services.

Uninsured Patients

If you are uninsured, unless you have qualified for financial assistance, payment is expected on the day of your visit. You will be asked to pay $100.00 as a deposit at check-in. The total charge for your visit will be provided at check out. If you need elective surgery, payment is expected prior to scheduling your procedure. You will be eligible for a 30% prompt pay discount, if you pay in full at the time of your visit or prior to surgical scheduling for the professional fees related to your visit or procedure.

Good Faith Estimate:

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit cms.gov/no surprises or call (443) 849-2450.

Insurance Coverage

It is your responsibility to know and understand the terms of your insurance coverage. Your insurance plan is a contract between you and your carrier. It is your responsibility to know whether your insurance carrier will pay for the services rendered.

HMO/Managed Care plans

If your insurance is an HMO or Managed Care plan, and you are seeing a GBMC primary care provider, you must have a GBMC provider listed as the Primary Care Provider (PCP) on your insurance card to be seen. If you are seeing a specialist, you may need a referral or pre-authorization. Please contact your insurance carrier with any questions regarding your coverage. Under the terms of your plan, the provider may not be able to see you without the proper PCP listing and/or the necessary referral or authorization, unless you are willing to sign a Voluntary Waiver of Insurance Benefits and agree to payment at the time of service.

Medicare

If we believe you are receiving a service that Medicare does not consider reasonable or necessary for your condition and for which payment is expected to be denied, you will be notified in writing with the Advance Beneficiary Notice of Non-Coverage (ABN) form prior to receiving the service. This will provide you with the opportunity to decide if you will proceed with the service ordered. This process is required by Medicare and preserves your right to appeal their decision. If Medicare denies payment, you will be financially responsible for the service.

Co-Pays, Deductibles, and Co-insurance

All co-pays are due at the time of service. Contractually, your insurance company requires us to collect the portion for which you are responsible at the time services are rendered. Deductibles and coinsurance amounts are due once notification by your insurance company has been received, either in an Explanation of Benefits (EOB) or a statement from GBMC.

Acceptable Forms of Payment:

We accept the following forms of payment: Cash, Check, money order, Visa, MasterCard, Discover and American Express. A fee of $25 will be assessed for each personal check returned by your bank as nonsufficient funds.

Payments and Correspondence

All payments or correspondence should be submitted through MyChart or mailed to:
GBMC Physician Self Pay
PO Box 418034
Boston, MA 02241-8034

Non-payment/Delinquent Accounts

You will receive a statement of your account each month either via mail or electronically through MyChart and may receive a phone call about unpaid balance. If you have a MyChart account, you are automatically enrolled in Paperless Billing and will only receive your statements electronically, unless you opt-out in MyChart.

If a balance remains unpaid for more than 90 days, the message on your third statement will state that your account is being reviewed for placement with a collection agency. Your account may be assessed a 30% surcharge to cover agency fees. You will be allowed 10 days to send the payment in full. Partial payments or extended payments will not be accepted unless otherwise negotiated with the Central Business Office at 888-571-2113.

I have read and received a copy of the GBMC Health Partners Welcome to Our Practice packet. By signing below, I acknowledge I will abide by the policies set forth in this packet.

If a patient is a minor or an adult without capacity to consent to their own care, please have the Health Care Decision Maker sign below.

X_____
(Patient Signature)

_____
(Print Name)

_____ _____
(Date) (Time)

X_____
(Authorized Health Care Decision Maker/Authorized Patient Representative Signature)

_____
(Print Name) (Relationship to Patient)

_____ _____
(Date) (Time)

Important Note for Health Care Decision Maker:

• All documents (Advanced Directive, Healthcare or Medical Power of Attorney, Health Care Agent, Legal Guardianship, Custody documents (both joint and sole custody)) must be presented at time of New Patient Appointment. Updates must be provided to practice.

GBMC
6701 North Charles Street
Baltimore, MD 21204

Place Patient Label Here

Acknowledgment of Receipt for GBMC HealthCare, Inc. Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that GBMC provide you with information about how we may use your Protected Health Information (PHI). All of that information is contained in GBMC's ***Notice of Privacy Practices*** ("The Notice") which you have received in a separate pamphlet. The Notice tells you:

- How GBMC may use and disclose your protected health information.
- Your rights with respect to the information and how you may exercise these rights.
- GBMC's legal duties with respect to the information.
- Whom you can contact for further information about GBMC's privacy policies.

I have received a copy of GBMC's Notice of Privacy Practices.

_____	_____	_____
Signature of Patient or Authorized Representative	**Date**	**Time**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

GBMC Health Partners

The Presbyterian Board of Governors
Cochlear Implant Center of Excellence
Registration Packet

Patient Name: _____
(Last) **(First)** **(Middle Initial)** **(Previous/Maiden Name)**

Date of Birth: _____ SS#_____

Sex/Gender

Sex (Legal): _____ (Female, Male, Nonbinary, Unknown, X)
Gender Identity: _____ Sex Assigned at Birth: _____ Sexual Orientation: _____

Address: _____
(Street # and Name) (Apt or Unit #)
City: _____ State: _____ Zip Code: _____

Home #_____ Cell #_____ Work # _____

PCP: _____ Referring Provider: _____

Email Address: _____ Preferred Language: _____

Marital Status:
___Single
___Married
___Divorced
___Widowed
___Legally Sep
___Partner

Race:
___American Indian or Alaska Native
___Asian
___Native Hawaiian
___Black or African Am.
___White
___Hispanic
___Other Race

Ethnicity:
___Hispanic
___Non-Hispanic
___ Refused to Report

Preferred Method of Communication:
___ Home #
___ Cell #
___ Work #
___ Mail
___ Email

Employment Status:
___Full time
___Part time
___Not employed
___Self employed
___Retired
___Active Duty Military

Student Status:
___Full time
___Part time
___Not a student

Employer Name: _____ Phone #_____Dept/Ext: _____

Employer Address: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ **Relationship**: _____
Home #: _____ **Cell**#: _____ **Work**#: _____
Address: _____ **Zip Code**: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____
ID#: _____ Group #: _____
Policy Effective Date: _____
Claims Address: _____
(Street # and Name) (City) (State) (Zip)

Phone: _____
Subscriber: _____ DOB: _____ Relationship to Patient: _____
Subscriber's Employer: _____ Employer's Phone#: _____
Referral Required: _____ Specialty Co-Pay: $_____

I certify that the demographic and insurance information on this form is current and accurate to the best of my knowledge.

X _____ _____ _____
Signature of Patient and/or Financially Responsible Party **Relationship (If 17 yrs or younger)** **Date**

Please complete ONLY FOR PEDIATRIC PATIENTS. If you are not a pediatric patient, STOP here.

Siblings (list all) **Children live with:** ☐ **Parents** ☐ **Mother** ☐ **Father** ☐ **Other**

Name_____DOB_____Social Security #_____
Name_____DOB_____Social Security #_____
Name_____DOB_____Social Security #_____
Name_____DOB_____Social Security #_____

Father's Name _____
Address _____
City _____
State _____Zip Code _____
Home Phone _____
Social Security #_____ DOB_____
Employer _____
Work Phone _____
Occupation _____

Mother's Name_____
Address _____
City _____
State _____Zip Code _____
Home Phone _____
Social Security #_____ DOB_____
Employer _____
Work Phone _____
Occupation _____

****Note: The parent who brings a child to the office for medical services is responsible AT THE TIME OF SERVICE for co-payments, deductibles, balances, or for payment in full, in the event the provider of service is non-participating with your insurance carrier.**

The Presbyterian Board of Governors
Cochlear Implant Center of Excellence at GBMC
6535 North Charles St, Suite 250
Towson, MD 21204

Patient History

Date: _____

Name: _____ Age: _____ Sex: _____

Social History:

Marital Status:
- ☐ SINGLE
- ☐ MARRIED
- ☐ DIVORCED
- ☐ WIDOWED

Spouses Name: _____

Occupation: _____ Full-time _____ Part-time _____

School: _____

Services provided at school: _____

Religious Denomination: _____ Religious Practices: _____

Hearing History:

Reason for Hearing Loss: _____

Date Diagnosed with Hearing loss: _____

Currently using hearing aids? If yes; age when hearing use began: _____

Yes ___ No___ RIGHT LEFT BOTH

If yes; please list the make, model and serial number(s):

_____

Communication: **ORAL SIGN TOTAL COMMUNICATION**

Telephone use:

Yes _____ No _____

Assistive Devices: (please circle all devices you currently use)

Closed Captioning **Amplified Telephone** **Cap Tel (Caption Telephone)**

Alerting/Flashing Device

Medical History: (circle/check if pertinent to your medical history)

Smoking: ☐ **YES** ☐ **NO** Alcohol: ☐ **YES** ☐ **NO** Exercise: ☐ **YES** ☐ **NO** Pregnant: ☐ **YES** ☐ **NO**

☐ Fever	☐ Heart problems	☐ Shortness of breath	☐ Arthritis
☐ Weight Loss	☐ Stroke	☐ Difficulty breathing	☐ Hives
☐ Blurred Vision	☐ High blood pressure	☐ Asthma	☐ Skin disorder
☐ Vision loss	☐ High cholesterol	☐ Stomach ulcer	☐ Migraine headaches
☐ Diabetes	☐ Sinus infections	☐ Acid reflux	☐ Severe nosebleeds
☐ Difficulty hearing	☐ Trouble swallowing		

Balance Disorders:

☐ Dizziness	☐ Stumbling	☐ Use of cane/walker	☐ History of falls

Psychiatric disorder: _____

Cancer: _____

Previous Surgeries & Dates (Ear, Nose, Throat, Eye, Stomach, Arm, Leg, etc.)

_____

_____

Current Medications: (prescription AND over-the-counter)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: (drug, food and other)

_____

_____

PATIENT CONSENT TO TREAT AND FINANCIAL AGREEMENT

Patient Name:_____ **Date of Birth:** _____

Consent to Treat: I consent to and authorize Greater Baltimore Medical Center, Inc., and their successors and assigns ("GBMC"), through their physicians and clinical staff, to provide medical treatment to me/the patient named on this consent form. I understand that health care providers in training, including students and resident physicians, may be involved in my care and treatment, and I consent to their participation in my care.

I understand that my provider may recommend, or I may request, under certain circumstances, to receive services via telehealth, which involves the use of electronic communications and information technology to provide health care services. I consent to receive appropriate services via telehealth.

E-Prescribe: I have read the ***Welcome to GBMC Health Partners*** packet and understand the benefits of E- Prescribing and would like my provider to e-prescribe my prescriptions. I certify that I have had the chance to ask questions and all my questions have been answered to my satisfaction.

_____I decline to participate with the E-Prescribe Program.

Assignments of Insurance Benefits and Third-Party Claims: I hereby authorize payment directly to GBMC of benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third-party payable by any person, employer, or insurance company to or for the patient unless the account is paid in full at the time of my visit. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate. I further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverages are subject to coordination of benefits clause.

I understand that I am responsible for any deductibles, coinsurance, or co-payments associated with my policy to include Point of Service (POS), Preferred Provider Organization (PPO), "opt-out" plan, "out-of-network" preferred, and indemnity benefits and for payment of services not covered under my policy or those services I elect to receive if denied for coverage by my insurer. I will contact my insurer or Health Advocacy Unit of the Attorney General's Office to learn how to appeal adverse decisions made by my insurer.

PATIENT CONSENT TO TREAT AND FINANCIAL AGREEMENT

Medicare/Medicaid Patient Certification (for Medicare/Medicaid patients only): I certify that the information I've given to apply for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

Photography and/or Video Record: Photographs and/or recordings taken for clinical reasons, such as to photograph and/or document a medical condition, help with the identification, and diagnosis and/or treatment of a condition, do not require written permission.

Communication Consent: I expressly consent GBMC and any of its agents to communicate with me for any reason, including debt collection efforts, using an automatic telephone dialing system, prerecorded voice or text message at the telephone number or numbers I provide even if I will incur a fee or a cost to receive such communications. I consent to GBMC or any of its agents communicating with me using any current or future means of communication, including but not limited to, automated telephone dialing systems, artificial or pre-recorded messages, SMS text messages, or other forms of electronic messages. I further promise to immediately notify GBMC if any telephone number, email address or other unique electronic identifiers or modes I provided to GBMC change or are no longer used by me.

I certify that I have read, understood, and agree to the above terms.

X_____

Signature of Patient (Print Name) Date Time

X_____

Signature of Authorized Patient Representative (Print Name) Date Time

_____

(Relationship to Patient)

Consent to Share Protected Health Information with Designated Contacts

It is GBMC HealthCare Inc. ("GBMC") policy not to release your medical information to family members or friends, except (i) to the parent/legal guardian of a non-emancipated minor; (ii) to other persons authorized by you, the patient; (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment); (iv) in emergency situations; or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and outlined in GBMC's Notice of Privacy Practices.

Through this form, you, the patient, or the patient's legal guardian, may designate one or more individuals who may receive protected health information (PHI) on your behalf. Your designated contacts **do not** have healthcare decision making abilities unless they are allowed to make such decisions by law, such as through a Medical Power of Attorney, Healthcare Decision Maker (via an Advance Directive), or Legal Guardianship.

You will be asked to review your designated contacts annually or it may be updated upon request.

Designated Contacts(s):

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

☐ I am not authorizing release of my PHI to any family members or friends.

_____ _____ _____

Signature of Patient or Legal Representative Date Time

_____

Printed Patient Name

_____

Printed Legal Representative name and relationship, if applicable

601-C69 (11/21)

* CONSENT *

GBMC – Release of Information
6701 North Charles Street Suite 3247 Baltimore, MD 21204
Phone: 443-849-2274 Fax: 443-849-3223 Email: medicalrecordrequests@gbmc.org

Authorization for Release of Protected Health Information – Page 1 of 2

Patient Information:

Patient Name	Birth Date

Address (include street, city, state and zip code)	Telephone No. ( )

Email Address (must be provided if electronic copies are requested)

Release of Information:

I hereby authorize:

☐ Greater Baltimore Medical Center
☐ Other facility name: _____

to release health information from the medical records of the above-named patient.

For the following purpose:

☐ At my request
☐ Insurance
☐ Continuance of Medical Care
☐ Legal
☐ Other: _____

To:_____

_____

Name/Address of person/organization to which disclosure is to be made

For treatment dates: _____

Type of Access Authorized:
☐ Paper
☐ Electronic Copy - CD
(treatment dates after 9/30/16)
☐ Electronic Copy – E-Mail
(e-mail address required)
☐ MyChart
(treatment dates after 9/30/16)

☐ **Continuing Care Information (Discharge Summary, History and Physical, Consultation, Operative Report, Diagnostic and Medical Tests, Pathology Report**
☐ **ER Record**
☐ **Laboratory Results**
☐ **Radiology Images & Reports (available on CD only)**
☐ **Other**_____

THIS IS A TWO PAGE FORM. THE PATIENT OR REPRESENTATIVE MUST SIGN ON PAGE 2.

This authorization will expire one year from the date signed below unless specific expiration event or condition is named here:
_____. The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this Authorization for Release of Confidential Health Information. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect the information to be used or disclosed, as provided in 45 CFR 164.524.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein described. I understand that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I acknowledge that the material authorized for release may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I understand that disclosure of health information to a party other than the one designated above is forbidden without additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this *"Authorization for the Release of Confidential Information."*

If electronic copies have been requested to be sent via e-mail, I have provided a valid e-mail address, either my own or that of my designated recipient. My records will be provided as an Adobe PDF. I will receive an e-mail from medicalrecordrequests@gbmc.org containing instructions for accessing my records.

_____ _____ _____
Date Time Patient's Signature

If you are **NOT** the patient but are signing on behalf of the patient complete the following:
I, _____,

Confirm that I am the legally appointed representative for the patient and I have checked the box to indicate my relationship to the patient below:

- ☐ Parent with Parental Rights
- ☐ Registered Kinship Care Relative
- ☐ Court Appointed Guardian
- ☐ Legally Appointed Healthcare Agent
- ☐ Medical Power of Attorney
- ☐ Power of Attorney with Right to See Medical Records
- ☐ Surrogate Decision Maker
- ☐ Court Appointed Personal Representative of Deceased

_____ _____ _____
Date Time Representative's Signature

_____
Address/Phone Number

You must attach proof of your authority to act on behalf of the patient as checked above (other than parent).

Fees/charges will comply with all laws and regulations applicable to release of information.

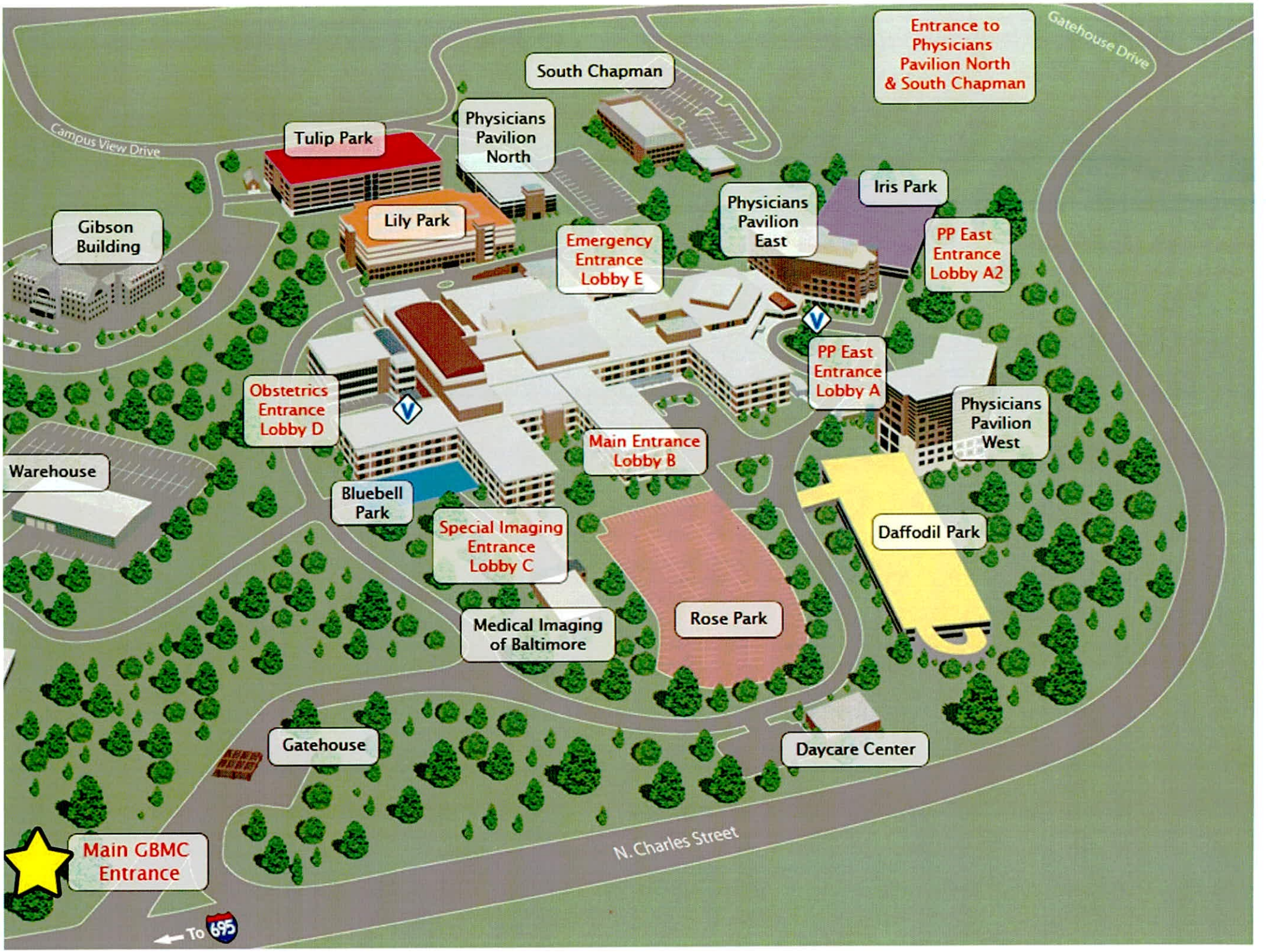
The Presbyterian Board of Governors
Cochlear Implant Center of Excellence
6535 North Charles Street, Suite 250
Baltimore, Maryland 21204
(443) 849-8400

Driving Directions

From Downtown Baltimore:
Take I-83 North (Jones Falls Expressway) to Northern Parkway exit.
Turn right onto Northern Parkway.
Follow to North Charles St. and turn left. Continue on North Charles St. for approx 2 miles.
Turn right into the main hospital entrance.
Follow signs to Physician's Pavilion North (PPN) and park in Tulip Garage.

From I-695 West (Baltimore Beltway):
Take Exit 25, Charles Street.
Proceed South on Charles St. (turning right off of the exit) for approximately 1.5 miles
Turn left into the main hospital entrance.
Follow signs to Physician's Pavilion North (PPN) and park in Tulip Garage.

From I-695 East (Baltimore Beltway):
Take Exit 25, Charles Street
Make a left off the ramp, onto Bellona Avenue.
Stay in left lane and follow traffic circle around to Charles Street.
Proceed South on Charles Street for approximately 1.5 miles
Turn left into the main hospital entrance.
Follow signs to Physician's Pavilion North (PPN) and park in Tulip Garage.


Entrance to Physicians Pavilion North & South Chapman
Gatehouse Drive
South Chapman
Campus View Drive
Tulip Park
Physicians Pavilion North
Iris Park
Physicians Pavilion East
Gibson Building
Lily Park
Emergency Entrance Lobby E
PP East Entrance Lobby A2
PP East Entrance Lobby A
Obstetrics Entrance Lobby D
Physicians Pavilion West
Main Entrance Lobby B
Warehouse
Bluebell Park
Special Imaging Entrance Lobby C
Daffodil Park
Medical Imaging of Baltimore
Rose Park
Gatehouse
Daycare Center
Main GBMC Entrance
N. Charles Street
To 695