Assumption of Risk and Authorization form for Interoperability Purposes (Consent Form)

I understand and agree that I authorize MedStar Health, Inc. and any of its agents and contractors (collectively, **MedStar Health**) to provide electronic access to my protected health information (Data) to the following individual who I am appointing as my personal representative (**Representative**):

First Name * _____ Last Name * _____

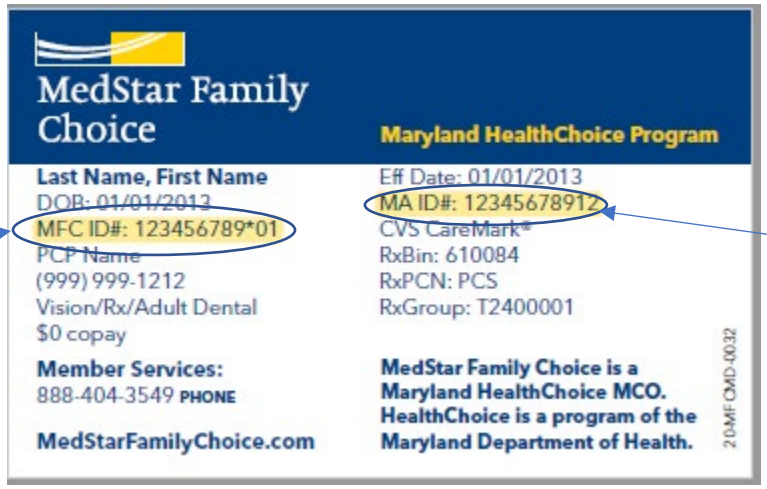
Mailing Address _____

_____

City, State, Zip _____

E-mail *_____ Phone: _____

MFC Member ID



Medicaid ID

Representing MFC Member ID *_____

Representing Member Medicaid ID_____

MFC Member ID of Personal Representative _____
(If personal rep is also a member)

Personal Rep ID _____
(If already assigned)

Relationship * (e.g., Legal Guardian, Parent of an adult member, Power of Attorney)
_____

Expiration date _____. (If no date entered, the authorization will remain in effect for one (1) year from the date sent to MedStar Family Choice.

I understand and agree to complete the **General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information** form and select the categories of Data I am sharing with this Representative.

I am aware of the risks involved in providing access to Data to this Representative. I have received a copy of MedStar Health's Privacy Notice and Notice of Privacy Practices. I understand that by releasing my data to the Representative it may no longer be confidential or protected by state and Federal law. More information is available online at www.medstarfamilychoice.com and I agree that I have reviewed this information. I have received sufficient information on the risks involved. I voluntarily assume the risk for providing access to my Data to this Representative, and fully understand the implications of providing this access.

MedStar Health does not condition treatment, payment, enrollment, or eligibility for benefits on the signing of this form. You have the right to revoke this form, except to the extent the custodian of records has already executed it, by downloading the online form and emailing it to MFC-Interop@medstar.net, with Personal Rep in Subject. You can also send your written request by mail with an Attention to: Interoperability Team, to MedStar Family Choice, 5233 King Ave., Rosedale, MD 21237 Attn: Interoperability.

I will not hold MedStar Health liable for negligence in the provision my Data to this Representative. I release all claims and litigation associated with the provision of access to my Data to the Representative and revoke my right to sue MedStar Health.

By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of Data and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this Data. If this form is submitted electronically, your typed signature is as binding as a written signature.

Member Signature (or POA, Guardian) if applicable: *

_____ Date: _____

Printed Name of Member: * _____

Note: *This form needs to be submitted with the General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information form.*