AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

For this authorization, "My Health Information" is:

__Complete Record
__Immunization Sheet
__Specific Notes _____
__Labs
__Limited records (last physical, shot record, growth chart, lead test)

For the dates starting: _____through _____

I authorize _____ to disclose My Health information to:

Dundalk Pediatrics Associates
2112 Dundalk Ave
Baltimore, MD 21222
Phone: (410)284-1133 Fax: (410)284-3371

Reason of Release: __ Transferring Primary Care __ Specialty Appointment
__ other (specify) _____

This authorization is valid for one year from date signed, unless I revoke this authorization. Dundalk Pediatrics may contact me to extend this authorization, but I do not have to do so.
Dundalk Pediatrics medical and administrative staffs are pledged to maintain strict patient confidentiality in keeping with high ethical standards and accordance with state and federal law. Dundalk Pediatrics has procedures in place to support this policy. These procedures make it very unlikely that my health information will be improperly redisclosed. However if this happens my health information may no longer be covered by these privacy protections. I am not required to sign this authorization. Dundalk Pediatrics does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. However, if I do not sign the authorization, my medical records will not disclose as requested.

Patient_____ Phone_____
DOB _____

Signature_____ Date_____
Print Name_____ Relationship to child_____