Authorization for Release of Medical Records

For this authorization, "My Health Information" is:

__ Complete Record (Fee of $.76 per page)

__ Immunization Sheet

__ Specific Notes __________________

__ Labs

__ Limited Records (Growth Chart, Shot Record, Lead and Last Physical *free of charge*)

For the Date starting: __________through__________

I hereby authorize Dundalk Pediatrics to disclose My Health Information to:

____

____

____

____

(Include facility/persons name, address, phone number, and fax number)

Reason of Release: __ Transferring Primary Care

__ Specialty Appointment

__ other (specify) ________________

- I understand that this authorization gives my/parent or legal guardian permission to release any Protected Health Information(PHI) that is contained in the Medical Record unless they specifically indicate "NO" next to the categories below:
  ___Substance Abuse Information
  ___Psychiatric/Mental Health Information
  ___HIV Information
- I understand that I may revoke this authorization in writing at any time except to the extent that Dundalk Pediatric Associates or its employees or agents have acted upon this authorization. My Written revocation must be submitted to:
  Dundalk Pediatric Associates
  1792 Merritt Blvd.
  Dundalk, MD 21222
- This authorization is voluntary and being made at the request of the individual/parent or legal guardian. I understand that the patient's health care and payment will not be affected if I do not sign this form.
- The released PHI may no longer be protected by Federal Privacy Laws and may be re-directed by the individual or organization to receive the PHI.
- This authorization will automatically expire one year from the date signed.

Patient______________________________ Phone________________________

Date of Birth_________________________

Signature____________________________ Today's Date___________________

Print Name___________________________ Relationship to child_____________