Authorization for Release of Medical Records

For this authorization, "My Health Information" is:

__ Complete Record

__ 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 _____ to disclose My Health Information to:

Dundalk Pediatric Associates
1792 Merritt Blvd.
Baltimore, MD 21222
Phone: (410) 284-1133
Fax: (410) 284-3371

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_____