Authorization to Release Medical Information
Arundel Pediatrics
www.arundelpediatrics.com

605 Global Way, Suite 119
Linthicum, MD 21090
Phone 410.789.PEDS
Fax 410.789.0425

1460 Ritchie Highway, Suite 209
Arnold, MD 21012
Phone 410.789.PEDS
Fox 410.349.1107

Patient Information'.

Print Name:_____ Maiden or prior Name:_____ Date of Birth: __ / _ / _

Address:_____Current Phone #_____

Healthcare Information coming from: Please release my healthcare information to:

605 Global Way, Suite 119
Linthicum, MD 21090
Phone 410.789.PEDS
Fax 410.789.0425

Name of Facility/Provider

City/State/2ip_
Phone/Fax____

Information to be released (please check the appropriate box): o
All medical records
- o The most recent 2 years of pertinent information (chart notes, labs, ultrasounds, and special tests)
- o Specific information (please specify) _____

Purpose for which disclosure is needed (please check the appropriate box):
- o I am transferring my care to a new Primary Care Provider
- o Legal investigation
- *o* Insurance Carrier Issues
- o Referral to Specialist
- o Personal/Other (please specify) _____

Patient Authorization
I understand that the information in my health record may include information relating to physical and/or mental illness. Sexually Transmitted Diseases (STDs), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). If requested in the future, Arundel Pediatrics is specifically authorized to relaease all health care information relating to such diagnosis, testing, or treatment.

Mv Rights
I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. I understand that once the health information is signed, I may in the future authorize to be disclosed to someone else, reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected by the HIPAA Privacy laws.

Important Information when Transferring Cere
I understand that as of the date I sign below, the above named patient will no longer *receive* care from Arundel Pediatrics, PA. This includes regular, evening, and weekend appointments or telephone calls including after hours calls. If the patient is interested in returning to Arundel Pediatrics, PA in the future as a patient, they may only do so if the practice is accepting new patients.

Fees for Copying Medical Records
Your prior health care provider, as well as Arundel Pediatrics may charge fees for the photocopying of your records. Please inquire of them what their fees are for this service.

Signature: _ _____ Date: _____OA Initials/Date/Time:
(Patient, Guardian*, or Authorized Representative*)------ 'Please provide documents to prove authority to sign on behalf of the patient)

If you are requesting this release of Medical Information and are not the parent or Guardian please specify below who you are and the facility or organization you are requesting disclosure for. _____

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SI6NED