

Authorization to Release Medical Information

Arundel Pediatrics P.A.

Patient Information:

Print Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Healthcare information coming from:

Name of Facility/Provider: _____

Address: _____

Phone: _____

Fax: _____

Please release my Healthcare information to:

Arundel Pediatrics
1460 Ritchie Highway, Ste 209
Arnold, MD 21012
Phone: 410-789-7337
Fax: 410-349-1107

Information to be released: (please check the appropriate box)

- All medical records to include items listed below
- The most recent 2 years of pertinent information (chart notes, lab results, imaging, specialist reports)
- Maternal medical history
- Family medical history
- Specific information (please specify) _____

Purpose for which disclosure is needed: (please check the appropriate box)

- I am transferring care to a new Primary Care Provider
- Legal investigation
- Insurance carrier issues
- Referral to specialist
- Person/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 related issues, Sexually Transmitted Diseases (STD's), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). If requested, in the future, Arundel Pediatrics is specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

My 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 release is signed, I may in the future authorize the information to be disclosed to someone else and once information is received by the noted recipient, that person or organization may re-disclose it, at which time the information may no longer be protected by the HIPAA Privacy Act.

Signature: _____

Date: _____

(Patient, Parent, Guardian*, or Authorized Representative* - *Please provide documentation to prove authority to sign on behalf of 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 this disclosure for. _____

1460 Ritchie Highway, Suite 209
Arnold, MD 21012
Phone 410.789.7337 Fax 410.349.1107

www.arundelpediatrics.com