

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

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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  
Fax 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:

Name of Facility/Provider

_____	605 Global Way, Suite 119
Street _____	Linthicum, MD 21090
City/State/Zip _____	Phone 410.789.PEDS
Phone/Fax _____	Fax 410.789.0425

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

- All medical records
- The most recent 2 years of pertinent information (chart notes, labs, ultrasounds, and special tests)
- Specific information (please specify) \_\_\_\_\_

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

- I am transferring my care to a new Primary Care Provider
- Legal investigation
- Insurance Carrier Issues
- Referral to Specialist
- 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 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 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 Care

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, Suardian\*, or Authorized Representative\*) -----\*Ptease 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 Suardian 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