Authorization to Release Medical Information

Arundel Pediatrics P.A.

Patient Information:

Print Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Healthcare information coming from:

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

Please release my Healthcare information to:

Name of Facility/Provider:
_____
Address: _____
_____
Phone: _____
Fax: _____

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

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

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

- o I am transferring care to a new Primary Care Provider
- o Legal investigation
- o Insurance carrier issues
- o Referral to specialist
- o 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 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.

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 afterhours 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.

Fee for Copying Medical Records: Your health care provider, as well as Arundel Pediatrics may charge fees for photocopying of your records. Please inquire regarding any current fees for this service.

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. _____.

THIS AUTHORIZATION WILL EXPIRE IN 90 DAYS FROM THE DATE SIGNED