AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Please check one and provide the requested information:

❒ I authorize Annapolis Pediatrics to release my Protected Health Information to the following person(s)/organization(s):

Name ____

Address ____

Phone Number _____________________ Fax Number _______________________

❒ I authorize ____ to release my Protected Health
(Primary Care Physician or Healthcare Provider)
Information to: Annapolis Pediatrics, 200 Forbes Street, Suite 200, Annapolis, MD 21401
Phone Number 410-263-6363 Fax Number 410-263-7551

(Please print)

Patient Name: ____________________________________ DOB: ___________________________

Patient Name: ____________________________________ DOB: ___________________________

Patient Name: ____________________________________ DOB: ___________________________

Patient Name: ____________________________________ DOB: ___________________________

Parent/Legal Guardian Name: ____

Address: ____

Home Phone: ______________________________ Cell Phone: ______________________________

Reason for Request (please check one):

❒ Transfer to another provider

❒ For appointment with specialist

❒ Insurance purposes

❒ Legal issues

❒ Personal use

❒ Other ________________________

In the state of Maryland, the physician who creates the patient's medical records is the owner of the records and is permitted to charge a processing and copying fee. **Annapolis Pediatrics charges a standard processing fee of $15.00 per child per copy.** This fee must be received *before* records will be released to you or your child's new physician. Upon receipt of fee, requests for release of medical records will take up to 14 business days to process.

I understand that medical records to be released may contain information related to HIV status, AIDS, sexually transmitted disease, alcohol or drug use, or mental health services, and hereby authorize release of the information.

This authorization expires one year from date of signature below. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to Annapolis Pediatrics. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

____ ________________________

Signature of Parent or Legal Guardian Date
(Patient must sign if 18 or over)