1. **I Authorize:**

____
Name of Sender

____
Street Address

____
City State Zip Code

2. **To Release to:**

____
Name of Receiver

____
Street Address

____
City State Zip Code

3. Information to be Released (check all that apply):

◯ Problem list ◯ Immunization record ◯ Growth Chart
◯ Lab reports ◯ Radiology reports ◯ Progress notes (including physicals)
◯ Other (please specify): ____

4. Records from the time period: ____/_____/_______ to ____/____/______
mm dd yyyy mm dd yyyy

5. Purpose for Release of Medical Information:

◯ Continued Medical Care ◯ Insurance claims ◯ Legal ◯ Personal Reasons
◯ Worker's Compensation Claims ◯Other (please specify): _______________________

6. Please Read and Initial that you understand and accept the following statements:

_____ I understand that this authorization will be valid for one year unless otherwise specified below.
Valid from: ____/____/____ to ____/_____/____

_____ The individual requesting records may be provided a copy of this authorization upon request. I also understand Maryland law requires Healthcare providers to release the requested information within 21 days of obtaining this written request.

_____ I understand if my protected health information is disclosed to someone that is not required to comply with HIPAA regulations, my information may be re-disclosed and no longer be considered protected.

_____ If this release pertains to alcohol, drug information, or mental health/psychotherapy problems, please understand that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR, part 2). The Federal rule prohibits you from disclosing this information unless it is permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical records or other information is not sufficient for this purpose. The Federal rules restrict any use of the information provided to criminally investigate or prosecute any alcohol or drug abuse patient.

_____I understand that I have the right to inspect my child's protected health information and make authorized changes and copies, if needed.

_____ I understand that Maryland Law allows a reasonable fee for the duplication of medical records. We are an Electronic Medical Record(EMR) provider and ,therefore, only offer records electronically. The fee for this is a flat rate of **$20.00** and the records will be provided on a password protected CD. If the receiving organization does not have the ability to accept records in this format, the entity completing this form will be responsible for receiving, printing, and providing these records to the appropriate party.

Patient Name: ______________________________ **Date of Birth:** ____/____/____ **Phone number:** _____-_____-________

Current Address: ____ ___________________ _____ ___________
Street City State Zip Code

Patient/Parent/Guardian Signature: ____ **Date:** ____/____/_____
(please circle one)