Main Office: 1475 Taney Avenue
Frederick, MD 21702

Main Phone: (301) 662-0133
Medical Records Phone: (301) 631-8055
Medical Records Fax: (301) 662-8108
www.thepedcenter.com

Authorization for Disclosure of Protected Health Information

If patient is 18 years or older, form must be completed & signed by patient. If patient is under 18 years of age, form must be completed & signed by parent/guardian.

Patient Information

Patient Last Name _____ Patient First Name _____ Patient DOB _____

Information to be Disclosed to:

I, the undersigned, hereby authorize The Pediatric Center of Frederick, LLC

☐ to ***release*** copies of medical records to: ☐ to ***obtain*** copies of medical records from:

Name of Person/Organization _____

Address _____

Telephone _____

Reason for Disclosure

☐ Relocation ☐ Child's Age ☐ Change of Insurance ☐ Specialist
☐ Other (please specify):

Information to be Disclosed

☐ Immunizations
☐ Records of office visits
☐ Copies of consultations from other physicians
☐ Developmental/ behavioral evaluations (if allowed)
☐ Other (please specify):

☐ Laboratory test results
☐ X-ray reports
☐ Newborn records
☐ Hospital summaries

Disclosure of Sensitive Information (if applicable)

Certain types of sensitive information require specific authorization to be released. Please indicate below if you would like the following types of information to be included in the release.

HIV/AIDS Testing or Treatment	☐ Y	☐ N	Substance Use/Abuse	☐ Y	☐ N
Pregnancy/Sexual Health	☐ Y	☐ N	Mental/Behavioral Health Information	☐ Y	☐ N

Signature

This authorization will expire within 1 year from the date of signature. I understand that I may revoke this authorization by submitting written notice of revocation to The Pediatric Center of Frederick, LLC.

Signature of Parent/Guardian or Patient (if 18 years or older) _____ Date _____

Printed Name _____ Relationship to Patient _____

Forwarding Address (if applicable) _____