

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

I hereby authorize the release of my medical records, original or copies of such records and that they are transferred to:

Maryland Pediatrics, P.C.
11185 Stratfield Court
Marriottsville, MD 21104
Phone: 410 442 – 4011
Fax: 410 442 - 4099

I hereby authorize the use or disclosure of my protected health information as described below. I understand that the information I authorize a person to receive, may be re-disclosed and no longer protected by federal privacy regulations.

Patient Name	Date of Birth	Patient Name	Date of Birth

Description of Information to be disclosed:

_____ Complete records to include yours and any medical records that has been sent to you

From previous doctors

_____ Abbreviated records: Immunizations record, growth chart and most recent physical exam

_____ Records covering from _____ to _____

_____ Hospital records: Newborn summary, discharge, Hep B verification

_____ Hospital records: Discharge summary from visit _____

_____ Others

Reason for request: _____ Continuity of care

_____ Transfer of primary care

Parent or Guardian Signature _____ Date _____