KENNETH M. KLEBANOW, M.D. & ASSOCIATES, P.A.
8821 Columbia 100 Parkway
Columbia, MD 21045
(410) 964-1318
FAX# (410) 715-0829

INVOICE

Date:

Patient(s**):** **DATE OF BIRTH** **CHART**

We have received your request for the transfer of your child's (children's) medical records. Please select which records you are requesting and return this invoice, a completed and signed Release form and your appropriate payment. Thank you.

_____ **Immunization Record Only** No Charge

_____ **Abbreviated Record** (Consists of the Immunization Record, Growth Charts, Notes from last Physical Exam.

$5.00 Per Child

_____ **Complete Records consists of: All Office visits, and referred outside Specialists**

(Please note: The following information will not be disclosed without specific authorization.)
(1) Information regarding HIV, Mental Health, Alcohol or Drug Abuse
(2) Records from Previous Providers

One Child	$15.00
Two	$25.00
Additional Children	$5.00 each

NOTE: MARYLAND LAW
Health-General Article Section 4-304(c)(3)

- **Health care provider may charge a fee for copying and mailing not exceeding 50 cents for each page of the medical record. In addition to the fee charged under subparagraph (i) of this paragraph, a hospital or a health care provider may charge:**
  - **A preparation fee not to exceed $15 for medical record retrieval and preparation**
  - **The actual cost for postage and handling of the medical record**

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Medical Records Form

Patient name: _____**DOB**: _____ **Date**: _____

Home address: _____ **Phone**: _____

If moving, New Home Address: _____

I hereby authorize Kenneth M. Klebanow, M.D. & Associates, P.A. to make uses and disclosure of my child/children's protected health information to the following entity:

Name of entity: _____
Street address: _____

Description of information to be disclosed:

o Immunization Record Only.
o Abbreviated Record (consists of the immunization record, growth charts, notes from last physical exam, and a summary of all visits since 1998 giving dates of visits, vital signs, diagnosis, treatment and labs.)
o Complete Records to include: All office visits and referred outside Specialists. **Please note: The following information will not be disclosed without specific authorization:** (1) Records from previous providers, (2) Information regarding mental health, HIV and/or substance abuse.
o Communication necessary to coordinate care.
o Behavioral Health consultation notes
o Records regarding treatment for the following condition or injury _____ on or about _____
o Records covering the period of time from _____ to_____
o Other (please specify - include dates.) _____

Reason for Release of Records: _____

To be read and signed by the parent or guardian:

1. I may revoke this authorization at any time by providing written notice to the practice.
2. I may not be able to revoke this authorization if the practice has already taken the action utilizing this authorization.
3. The Practice will not condition treatment or payment based on my signing this authorization.
4. I am signing this authorization freely and no one has pressured me to sign it.
5. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
6. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
7. I have received a copy of this authorization.

Parent or guardian's signature: _____
Relationship to the patient: _____ **Date**: _____