NORTH PARK PEDIATRICS, LLC

AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED MEDICAL INFORMATION

PLEASE READ CAREFULLY AND FILL OUT THE FORM COMPLETELY.

1. I AUTHORIZE: TO RELEASE TO:

_____ _____
Name of Medical Organization Name of Organization/Parent

_____ _____
Street Address Street Address

_____ _____
City State Zip Code City State Zip Code

_____
Daytime phone number

INFORMATION TO BE RELEASED (Check all applicable)

_____Patient Problem List (no fee) _____Immunization Records (no fee) _____Growth Charts (no fee)

_____ All Office Records (copy fee is $0.76 per page) _____ Last 2 years of Office Records (copy fee is $0.76 per page)

RECORDS FROM TIME PERIOD _____ TO _____

Reason for Disclosure: _____Continued Medical Care _____ Payment of insurance claims _____ Legal
_____ Workers Compensation Claim _____ Transfer of medical care to another physician _____ Personal
_____ Other: _____

Please Initial

_____ I understand that I may be provided with a copy of this authorization.

_____ I understand that if my protected health information is disclosed to someone who is not required to comply with the Federal Health Portability Act (HIPAA) regulations, then such information may be re-disclosed and would no longer be protected.

_____ If this release pertains to alcohol, drug information, mental health problems or psychotherapy, please note that this information has been disclosed to you from records protected by the Federal Confidentiality Rules. The Federal Rule prohibits you from making further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rule restricts use of information to criminally investigate or prosecute an alcohol or drug abuse patient.

_____ I understand that I have the right to inspect my child's protected health information.

_____ I understand that a fee of $0.76 per page will be charged for the duplication of records.

_____ I understand that I will receive advance notice regarding the total due for record duplication.

_____ (For Professional Offices and Lawyers Only) I understand that a preparation fee of $22.88 will be charged. Please note that these fees have been set forth by Maryland law codified in the Health-General Article 4-304 (c) (3).

_____ _____/_____/_____ _____
Patient Name Date of Birth Daytime phone number

_____
Street Address

_____
City State Zip Code

Please indicate reason for transfer: _____Relocation _____ Medical Insurance _____ Transition to Adult Doctor

Dissatisfaction: (please explain)

_____

_____

Other: (please explain)_____

_____ _____ _____ _____/_____/_____
Signature **Relationship to Patient** **Printed Name** **Date**

Authorization to release rec rev 7.2017