

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 \$0.83 per page) ____ Last 2 years of Office Records (copy fee is \$0.83 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 \$0.83 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