NORTH PARK PEDIATRICS, LLC

AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED MEDICAL INFORMATION

I AUTHORIZE: North Park Pediatrics, LLC 4 C North Ave, Suite 403, Bel Air, MD 21014

To Release Medical Information to:

_____ _____

Parent name/Patient name if over 18/Medical provider name Phone number

_____ _____

Street Address Fax number (if applicable)

_____

Information to be Released (please check one only):

_____ Immunization Records, Growth Chart, last 2 years (August 2020-present) of medical records, lead levels, newborn screen results (no charge-one time only). This will include any records that pertain to alcohol, drug information, mental health problems or psychotherapy unless you specifically indicate otherwise.

□ Check this box if you DO NOT want records that pertain to alcohol, drug information, mental health problems or psychotherapy included

_____ All Office Records **(COPY FEE OF 0.83 CENTS PER PAGE, WHICH MUST BE PAID IN ADVANCE)**

_____ Records from _____ to _____ **(FEE MAY APPLY WHICH MUST BE PAID IN ADVANCE)**

_____ Other (Please specify exactly what you want from the chart- **FEE MAY APPLY WHICH MUST BE PAID IN ADVANCE**) _____

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. The fee must be paid prior to copying of the records.

_____ (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

_____ _____ _____/_____/_____

Signature (must be patient if 18 years or older) **Relationship to Patient** **Date**

_____

Printed Name