



Gold Pediatrics LLC

15005 Shady Grove Rd., Suite 450
Rockville, MD 20850
Errol K. Douglas, M.D., F.A.A.P.
(301)517-9710 Phone (301)517-9713 Fax

Patient Request for Medical Records Form Authorization to Disclose/Release Protected Health Information

Patient(s) Name: _____ Date(s) of Birth: _____

Patient(s) Address: _____ Acct.(s)/Chart(s): _____
Street Address _____

Phone Number cell: _____
City, State, Zip Code home: _____

For Record Release: By signing this authorization, I authorize the entity entered below to disclose (PHI) protected health information about myself and/or child(ren) to Gold Pediatrics LLC. It is my right to revoke this authorization at any time, in writing to the address listed below provided the requested information has not yet been disclosed/released.

Previous Provider/Specialist

Street Address

City, State, Zip Code

Phone# Fax#

Release Records to: **GOLD PEDIATRICS LLC**
If provider uses eClinical Works or 15005 Shady Grove Road, Suite 130
please send records via eCW P2P Rockville, Maryland 20850

Information to be Released:
 All Records Labs Dates of Service: _____
 X-ray(s) Growth Charts Immunizations
 Pre Op. Most Recent WCC Other: _____

Reason for Record Release:
 Provider Change Moved Insurance Change
 Other

Signature of Patient or Legal Guardian Printed Name of Patient of Legal Guardian Date

This authorization permits: Gold Pediatrics LLC at 15005 Shady Grove Road Suite 130 Rockville, MD 20850 to use information requested from and disclosed by the above listed Provider/Specialist. I understand that this authorization is valid for one year from the date on which it was signed.

FOR INTERNAL PURPOSES ONLY: NAME & TITLE OF PERSON SUBMITTING REQUEST FOR RECORDS: _____

FAXED EMAILED MAILED

TO: _____ ON: _____