Bel Air and Havre de Grace Pediatric Centers

Authorization of Release of Medical Information

602 S. Atwood Road

Suite 104

Bel Air, MD 21014

419 S. Union Avenue

Havre de Grace, MD 21078

I hereby authorize the use/disclosure of my/my child's health information as described below. I **UNDERSTAND** that this authorization is voluntary. I **UNDERSTAND** that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I **UNDERSTAND** that a photocopy or fax of this authorization is as valid as the original. I **UNDERSTAND** that I must provide identification with this release in order for it to be valid.

Patient Name:_____ Date of Birth:_____

Address:_____ Phone:_____

_____

Please release my healthcare information from:

Name of Provider:_____

_____

Address:_____

City/State/Zip:_____

Phone:_____

Please send my healthcare information to:

Name of Recipient:_____

_____

Address:_____

City/State/Zip:_____

Phone:_____

INFORMATION TO BE RELEASED

___ The most recent one (1) year of pertinent information (chart notes, labs, vitals, immunizations)

___ Specific information (please specify)_____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE:

___ Sharing with other healthcare providers

___ Medical/Legal

___ Moving

___ Personal use

___ I am transferring my care to a new healthcare provider

___ Insurance Change

PATIENT AUTHROIZATION:

I **UNDERSTAND** that my medical records are confidential. I **UNDERSTAND** that by signing this authorization I am allowing the release of my requested medical information to the agency or person specified above.

I **UNDERSTAND** that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human ImmunodeficiencyVirus (HIV), mental health records, drug and alcohol treatment records, or ADD/ADHD treatment records. Bel Air/Havre de Grace Pediatrics is specially authorized to release all health care information relating to such diagnosis, testing or treatment.

I **UNDERSTAND** that I have a right to a copy of my Protected Health Information (PHI) for a fee or to inspect the disclosed (PHI) information if so requested. All medical records are mailed to the physician's office and will be copied for a set fee per page per the state of Maryland.

I **UNDERSTAND** that I may revoke this authorization at any time by notifying Bel Air/Havre de Grace Pediatrics in writing. I understand that this revocation will not apply to information that has already been release in response to this authorization. This authorization expires in/on _____. (insert applicable date)

Parent or guardian's signature:_____ Relationship to Patient:_____

Witness Signature: _____ Date: _____

Rvd 2/22/2021