Frederick Pediatric Associates

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# MEDICAL RECORD RELEASE FORM

## PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

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Child's Name: _____ Date of Birth: _____

Patient(s) Address: _____ Contact cell #_____

City, State, Zip:_____

By signing this form, I verify that I am the patient, or the parent / legal guardian of the child(ren) named above, with the authority to request medical records, and I authorize FREDERICK PEDIATRIC ASSOCIATES PA

☐ to ***Release*** copies of medical records to: ☐ to ***Obtain*** copies of medical records from:

Name of Physician or Clinic:_____

Complete Address: _____

Phone Number: _____ Fax Number: _____

**Reason for the Disclosure :** ☐ Moving ☐ Change of Insurance ☐ Child's Age ☐ Specialist

☐ Other (specify)_____

**Information to be Disclosed:**

☐ Complete Medical Record

☐ Full Medical Record with the following exclusions: _____

☐ Basic Medical Record (Medication List, Immunizations, Vitals, Last Well Visit Note)

☐ Other: _____

This authorization will expire 1 year from the date I have signed this form. I understand that I may revoke this authorization at any time by notifying Frederick Pediatric Associates in writing and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. By my signature on this form, I also agree to pay any requested fees as established by Maryland House Bill 724.

_____ _____

**Printed Name of Patient (18+), Parent, or Guardian** **Signature of Patient (18+), Parent or Guardian**

**Relationship to Pt** _____ **Date:**_____