Partners in Pediatrics & Family Health

303 W. MEMORIAL BLVD., W.
HAGERSTOWN, MARYLAND 21740
Phone: 301-791-7060 Fax: 301-791-8990

Authorization for Release of Patient Identifiable Health Information

Date of Request: ____________

I, ________________________________ hereby authorize Partners in Pediatrics and Family Health.

_____________ To Release To _______________ To Obtain From

____
Name of Physician, Hospital, Insurance Company, Self, Etc.

____
Address, City, State, Zip code

The following information will be released from the Medical Records of:

________________________________ ___________ ____________________
Patient Name D.O.B Social Security Number

Specific Information to be disclosed: ____ Entire Medical Record ____ Immunization Record
____ Other (please specify) ____________________________

This Health Information is need for:

___ Personal Use ___ Continuing Medical Care ___ School
___ Leaving Practice ___ Legal Reasons ___ Military
___ Social Security Disability ___ Other

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immuno-deficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, or communicable disease. I authorize the disclosure of the specific information.

Sign : ________________

- I also understand that the person giving authorization by written and dated notice to the Medical Record Department may revoke this authorization. Iniial ____________
- I understand that this revocation will not apply to information that has already been released in response to this authorization.
- I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Initial: ______________
- This authorization expires one year from the date of signature, unless I specify otherwise or revoke it, Initial : __________
- I understand I may be charged for copies of my healthcare information. Initial :_______________
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information. Iinitial : __________________
- I understand authorizing the use or disclosure of the health information identified above is voluntary. I need not sign this to ensure healthcare treatment. Initial :______________

________________________________ ________ ______________________________ ________
Signature of Patient Date Signature of Parent (If Minor Patient) Date

There is a $25 charge for copy of each complete medical record for those transferring from this office.
Note that this document is valid for only one year.