AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Please check one and provide the requested information:
The completed form can be faxed to 410.263.7551, dropped off at any Annapolis Pediatrics location OR emailed to medicalrecords@annapeds.com

☐ I authorize Annapolis Pediatrics to release my Protected Health Information to the following person(s)/organization(s):

Name _____

Address _____

Phone Number _____ Fax Number _____

☐ I authorize _____ to release my Protected Health
(Primary Care Physician or Healthcare Provider)
Information to: Annapolis Pediatrics, 200 Forbes Street, Suite 200, Annapolis, MD 21401
PhoneNumber410-263-6363 FaxNumber410-263-7551

Documents requested:

☐ Entire Chart ☐ Immunization Record Only (no charge) ☐ Visit Date: _____

☐ Documents Regarding: _____ ☐ Labs Regarding: _____

{Pleaseprint)

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Reason for Request (please check one):

☐ Transfer to another provider ☐ Legal issues ☐ For appointment with specialist

☐ Personal use ☐ Insurance purposes ☐ Other _____

In the state of Maryland, the physician who creates the patient's medical records is the owner of the records and is permitted to charge a processing and copying fee. Medical records preparation (if records are being released to you or another physician) is $25.00. The fee is an out of pocket expense and cannot be billed to your insurance carrier. If records are being provided to someone other than patient or physician, there is an additional preparation fee of $22.88. This fee must be received *before* records will be released. Upon receipt of fee, requests for release of medical records will take up to 14 business days to process. Request for an immunization record ONLY is no charge.

I understand that medical records to be released may contain information related to HIV status, AIDS, sexually transmitted disease, alcohol or drug use, or mental health services, and hereby authorize release of the information.

This authorization expires one year from date of signature below. I understand that I have a right to revoke this authorization at anytime. My revocation must be in writing in a letter provided to Annapolis Pediatrics. I further understand that If the person(s) or organization(s) authorized to receive the information is not a health plan or healthcare provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

_____ _____

Signature of Parent or Legal Guardian Date

{Patient must sign if 18 or over)