



# Medical Record Release Authorization

7350 Van Dusen Road Suite 110, Laurel, Maryland 20707 Phone: (301)-498-8880 Fax: (301)-498-7939

Patient Name \_\_\_\_\_ Maiden Name \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell/Work \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Email Address: \_\_\_\_\_

### A) I hereby authorize records FROM:

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

### B) To be released TO:

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone# \_\_\_\_\_ FAX# \_\_\_\_\_

### C) For the purpose of:

\_\_\_\_\_

### D) Records Format:

Records will always be delivered via user friendly CD or secure fax unless notated here:

Please send printed copies via postal mail

Date Range _____ to _____	
<input type="checkbox"/> Physicians Office Notes	<input type="checkbox"/> Cardiology/EKG Reports
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Lab/Path Reports
<input type="checkbox"/> Operative/Procedure Reports	<input type="checkbox"/> Radiology/XRay/MRI Reports
<input type="checkbox"/> Other _____	

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient/Parent/Guardian or Authorized Representative) **\*\*Subject to Fees**

This authorization will expire one year from the above date unless I specify an expiration date: \_\_\_\_\_  
(Expiration date of authorization)

**\*PLEASE READ Fee Information:** MedPeds LLC contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the fee schedule as set by the state of Maryland: a \$22.88 handling fee, \$0.76 per page and postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as a courtesy.