Medical Record Release Authorization

7350 Van Dusen Road Suite 130, 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_____

☐ Physicians Office Notes ☐ Cardiology/EKG Reports

☐ Immunizations ☐ Lab/Path Reports

☐ Operative/Procedure Reports ☐ Radiology/XRay/MRI Reports

☐ Other _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I hereby release any one, or all of you collectively, from any and all legal responsibility that may arise from the above act authorized by me.

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 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.

_____ _____****Subject to Fees**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

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 $22.09 handling fee, $0.73 cents 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.