Ellicott City Pediatric Associates
9011 Chevrolet Dr., Suite 1-6, Ellicott City, MD 21042 Tel: 410-465-7550 fax: 410-465-6359

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

☐ Mail to Medical Office* ☐ Mail to My Address* ***mail fee is $8.50 + fee for copying Medical Records***

☐ Fax to New Provider (we will fax only Abbreviated PHI) ☐ Will Pick Up Records

I authorize Ellicott City Pediatric Associates to release my (or my children's) Medical Records to the following person/organization:

Name ____

Address: ____

Phone number _______-_______-_________ Fax# _________-________-_________

Documents requested:

Please note: If patient's last visit was before 2012, the Paper copy or Abbreviated is the only choice.

☐ **Entire Chart** (check one)

- ○ **Paper copy** (fee for Paper copy .76 cents for each page- call for an estimate cost)
- ○ **CD** (fee $20 first patient; $10 each additional patient if done at the same time and on the same CD – password protected PDF file
- ○ **USB Flash drive** (fee $20 first patient; $10 each addition patient if done at the same time and on the same USB – password protected PDF file)

☐ **Abbreviated PHI** (No Charge) : Immunization Record, Growth Chart, last Physical, Recent Lab

☐ **Other Document Request :** ____
Charges may apply ____

Patient Name: ____ DOB: ____________________
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Patient Name: ____ DOB: ____________________

Reason for Request

○ Transfer to another provider – Provider name_______________________________Phone#__________________________
reason____

○ Legal Issues ○ Personal use ○ Insurance purposes ○ Other _______________________________________

I understand that medical records to be released may contain information related to HIV status, AIDS, sexually transmitted disease, alcohol or drug use, mental health services, or any other information entered into my chart, and I hereby authorize release of the information. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws.I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has been taken.

Patient/Parent/Legal Guardian Name___________________________________ **Phone#:** ________-__________-__________

Address:____

_____________________________________ _____________________

Signature of Patient, Parent or Legal Guardian **Date**
(Patient must sign if 18 or over)

Updated 02/2020