

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

- Mail to Medical Office* Mail to My Address* ***mail fee is \$8.00 + 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)
- CD** (fee \$20, additional CD 50%off – password protected PDF file)

(Password will be given only to Parent/Guardian or Patient over age of 18**)**

- Abbreviated PHI** Immunization Record, Growth Chart, last Physical, Recent Lab,
No Charge Visit History Summary
- Other Document Request :** _____
Charges may apply _____

Patient Name: _____ **DOB:** _____
Patient Name: _____ **DOB:** _____

Reason for Request

- Transfer to another provider (we are no longer your PCP) – 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
(Patient must sign if 18 or over)

Date