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* ☐ Will Pick Up Records ☐ Mail to My Address*

mail fee is $8.00 + fee for copying Medical 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** No Charge — Immunization Record, Growth Chart, last Physical, Recent Lab, Visit History Summary

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

Patient Name: ____________________ DOB: __________
Patient Name: ____________________ DOB: __________
Patient Name: ____________________ DOB: __________

Reason for Request

○ Transfer to another provider ○ Legal Issues ○ For appointment with specialist ○ 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