Authorization for Release of Information

Patient Information: Print Name: _____ Date of Birth: _____

Please release my healthcare information from:

Name of Facility/Provider: _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____

Fax Number: _____

Please send my healthcare information to:

Name of designated recipient:

V Care Pediatrics

Address: **11200 Scaggsville Rd, ste 120**

City/State/Zip Code: **Laurel MD 20703**

Phone Number: **240-360-5992**

Fax: **855-371-0566**

Information to be released

_____The most recent 2 years- of pertinent information (chart notes, labs, ultrasounds and special tests)

_____All medical records (please note we are not authorized to give you medical records that we received from outside sources)

_____Vaccination record, recent complete physical exam and growth chart

Purpose for which disclosure is being made

____Sharing with other health care providers

____Legal Investigation

____I am transferring my care to another provider:

____Reason for transferring care:

_____Personal use

____Other:

Patient Authorization

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). Pediatric Place is specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

My Rights

I understand that I do not have to sign this authorization in order to obtain health care benefits (payment, treatment or enrollment. I may revoke this authorization in writing. To view the process of revoking this authorization, please read the Privacy Notice to patients available at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time I may no longer be protected under Privacy laws.

Fees for Copying Medical Records

Our charges to release records to a patient or relative are as follows: $.83 cents per photocopied page for paper records, $.62 for electronic records. In addition, the actual cost of shipping and handling charges will apply. This fee must be paid before your records can be released.

I understand the I may be charged at the rates shown above for the copies of the records I have requested and for the postage, I agree to pay the total charges upon receipt of the copies.

Signature: _____ Date_____

*Please provide documents to prove authority to sign on behalf of patient

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED