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MEDICAL RECORD RELEASE AUTHORIZATION FORM

Law requires the following information before we can release the medical records of your child. See MD Ann Code, Head General, Title 4, Subtitle 3

Patient Name:_____ Date of Birth:_____

Address:_____

MUST CHECK ONE:-
___ TO RECEIVE RECORDS FROM ___ TO SEND/MAIL RECORDS TO

Complete name and address of the recipient of this record or to whom this request should be sent.

Name:_____

Address:_____

City:_____ State:_____

Phone:_____ Fax:_____

Please Check Reason for Release:-

___ Moving (New Address)_____

___ Insurance Change ____ Unhappy with staff provider ____ Other (Please Specify)

Other:_____

Please Note: WE DO NOT COPY INFORMATION GENERATED BY OTHER PHYSCIANS/OFFICES

Which documents are you requesting?

___ Pertinent office medical records (last visit, last physical/well check, lab work, growth chart & immunization record- $5.00)

____ All office medical records ($15 administrative fee and $0.60 per copied paper)

___ Immunization record only

Copy Fee:-
Requests by the patient/parent and any request from other parties (i.e. Attorney, disability, insurance company, personal representative self) will be charge in compliance with Maryland Law (Health-General Article 4, 303, Oct 1,1994) as outlined. Parties requesting copies of records will incur a $15 charge for records retrieval plus $.50/page copied. If records are mailed, a postage charge will be incurred. Copies that are requested should be provided within three (3) business days. If we are able to comply with the request, an additional $10.00 charge will be incurred.