Cambridge Pediatrics, LLC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(301) 645-1133 Phone & (301) 645-2369 Fax

_____ _____
(Print patients full name) Birth date (Mo/Day/Yr)

_____ _____
(Street address) Social security number

_____ _____
(City, state, zip code) Phone (Home)

At the request of the individual, I _____, do hereby authorize *Cambridge Pediatrics, LLC* to release:
(Patient's Name or Parent Name if patient is **under**18)

DATES OF_____

_____DISCHARGE SUMMARY	_____PATHOLOGY REPORTS	_____EMERGENCY REPORTS
_____HISTORY & PHYSICAL	_____LABORATORY REPORTS	_____SHOT RECORDS
_____PROGRESS NOTES	_____RADIOLOGY REPORTS	_____LAST 2 YEARS ONLY
_____OPERATIVE NOTES	_____ECG/EEG/CARDIC CATH	_____OTHER_____

_____ I do ____I do NOT authorize release of mental health records; psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

_____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection,

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

_____
Street address

_____
City, state, zip

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST	_____INSURANCE	_____WORKERS COMP	_____LEAVING PRACTICE
_____LEGAL INVESTIGATION	_____DISABILITY DETERMINATION	_____PERSONAL	_____ RELOCATION

OTHER (SPECIFY)_____

Please provide current <u>DAYTIME</u> telephone number in the event we need to contact you: (____)_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate (Power of Attorney must be on file with office or accompanying this request.) **Date**

Patient Medical records are available in electronic format via our patient portal at no charge. Please contact our office at (301) 645- 1133 if you need assistance logging in. **PLEASE NOTE:** <u>There is a charge for a personal copy or the permanent transfer of your records. Maryland State Rates apply at $0.76 per page, plus first class postage for printed medical records. For patients requesting a copy of their medical records in CD or Flash Drive format, the cost is $0.62 per page, plus $3.50 for a CD or $10.00 for a flash drive and the actual cost of postage</u>**.** *<u>PRINTED MEDICAL RECORDS, CD OR FLASHDRIVE ARE RELEASED BY CAMBRIDGE PEDIATRICS, LLC ONCE PAYMENT IS RECEIVED</u>*. **<u>For patients with Medical Assistance, MD State guidelines apply.</u>**

ENTIRE_____ LAB_____ EKG_____
DS_____ EKG_____ IMMUNE_____
OP_____ X-Ray_____ OTHER_____
HP_____ PATH_____ _____
NUMBER OF PAGES_____ _____

_____
ROI SPECIALIST

_____
DATE

(Policy Updated February 15, 2021)