

Forest Hill Pediatrics, LLC
2005 Rock Spring Road, Suite 1
Forest Hill, MD 21050
Phone: 410.420.1743
Fax: 410.420.3520

Authorization for Release of Medical Information

<hr/> <i>Patient's Last Name, First Name</i>	<hr/> <i>Patient's date of Birth</i>
<hr/> <i>Street Address</i>	<hr/> <i>Patient's Social Security No.</i>
<hr/> <i>City, State, Zip Code</i>	<hr/> <i>Home Phone No.</i>

I hereby authorize _____ to release the indicated health information on the above named patient:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Emergency Reports | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Other _____ | | |

I do I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I do I do NOT wish to have my information faxed.

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PURPOSE OF DISCLOSURE:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Insurance | <input type="checkbox"/> Transfer or Care | <input type="checkbox"/> Legal Investigation |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Daycare/School | <input type="checkbox"/> Personal | <input type="checkbox"/> Other _____ |

Reason for Transfer: _____

Please provide current telephone number in the event we need to contact you: () -

I hereby authorize disclosure of the health information for the above named patient. I understand that the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state HIPAA Laws they might further disclose the health information, and it may no longer be protected by health information privacy laws. I understand that this authorization for release of medical records is valid for sixty (60) days and can be revoked in writing at any time except to the extent that the disclosure made in good faith has already occurred in reliance on the consent.

<hr/> SIGNATURE OF PATIENT OR LEGAL GUARDIAN OF PATIENT	<hr/> DATE
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Relationship to the Patient: _____