Bay Pediatric Center 606 Dutchman's Lane, Easton, MD 21601 410-763-8272 (f) 410-763-6014

Transfer Records to Bay Pediatric Center

# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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Patient Last Name,First Name, MI Date of Birth(mm-dd-yyyy)

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|---|---|
| Transferring from: Name | |
| Address | |
| City, State, Zip | |
| Fax if Applicable | |

As the parent/guardian of the above named child(ren)I, hereby request and authorize the disclosure of my child's protected health information to the Bay Pediatric Center.

The purpose of this disclosure is for enclosure and accuracy of their medical history.

I specifically request and authorize release of all information regarding services rendered to my child from _____ to_____.
(Date) (Date)
Such information is to include History and Physical, Results of Diagnostic Testing, Operative, therapy and procedure records and Discharge summaries. In addition, I authorize the disclosure of information contained in the highly confidential categories of mental health, substance abuse, HIV status and sexually transmitted diseases.

I understand I am voluntarily signing this authorization and that the information that is released will no longer be protected under the federal privacy laws. I also understand that this authorization will expire 90 days from the date of signing unless revoked earlier by me in writing and can not be withdrawn after the disclosure.

I hereby authorize that A PHOTOCOPY OF THIS REQUEST SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

Date _____ Signature _____

Printed Name of Parent/Guardian_____

Date _____ Signature of Witness _____