Transferring Records to

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

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Last Name	First Name	MI	Sex	DOB

Transferring From	
Address	
City, State, Zip	
Fax Number	

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.

1) Last Well Visit/Medication Consults
2) Immunization records
3) Most recent labs, **to include lead results**
4) Summary of care
5) Any pertinent information

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this authorization will expire 90 days from the date of signing unless revoked earlier by me in writing and can not be withdrawn after the disclosure.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.

Printed Name of Parent /Guardian: _____

Address of Parent/Guardian: _____

Phone Number: _____ Email Address: _____

Date: _____ Signature: _____