

Chesapeake Pediatrics & Adolescent Associates, P.A.
106 Milford St., Suite 201 Salisbury, MD 21804
410-543-1616 * Fax 410-543-8497
29 Broad St. Ste. 201 Berlin, MD 21811
410-543-1616 * Fax 443-513-3184
www.chesapeakeped.com

MEDICAL RECORD RELEASE AUTHORIZATION FORM

Patient Name: _____ **Date of Birth:** _____

Phone: _____ **Address:** _____

RELEASE MEDICAL RECORDS FROM:

DISCLOSE MEDICAL RECORDS TO:

Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____
Fax: _____

Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____
Fax #: _____

I AM REQUESTING MEDICAL RECORDS FOR DATES: FROM: _____ TO: _____

REASON FOR REQUEST (PLEASE CHECK ONE):

Transfer to Another Provider Legal/Custody Purposes Appt. with Specialist
 Personal Use Insurance Purposes Other _____

INFORMATION TO BE RELEASED:

Last Physical & Immunizations Immunization Records Only Lab Results
 Entire Records Other Specified Records _____

Request Electronic Format/Disc _____ **Request Paper Format** _____

I authorize the release of copies of medical records and/or other information as noted above. If specifically indicated by me above I understand that this may include information concerning the following: psychiatric/psychotherapy records, mental health records, drug and alcohol treatment information, specific confidential HIV-related information, and/or any general physical condition information. I authorize this information be released by routine mail or pick-up. I understand that I may revoke this authorization at any time to the extent that the person who is to make the disclosure has already acted in reliance on this authorization. If not revoked earlier, this consent will remain in effect for thirty (30) days and will only be accepted if completed in its entirety.

Signature of Patient or Parent/Guardian (if patient is under 18)

Date

Print Name of Patient or Parent/Guardian (if patient is under 18)

Relationship to Patient