Chesapeake Pediatrics

MEDICAL RECORD RELEASE AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone: _____ Email: _____

RELEASE MEDICAL RECORD TO CHESAPEAKE PEDIATRICS:

I authorize release of my child(ren)'s medical records to: Chesapeake Pediatrics, 106 Milford St. Ste 201 Salisbury, MD 21804 from

_____ fax: _____

(Previous Medical Provider &/or Other Healthcare Provider)

DISCLOSE MEDICAL RECORD: **FROM:** _____ **TO:** _____

I authorize Chesapeake Pediatrics to release my child(ren)'s medical records to:

Parent/Patient/Patient Representative:

Email: _____

CD Address: _____ City/State/Zip: _____

Release to Other Medical Practice:

CD: Name: _____ Phone#: _____

Address: _____ City/State/Zip: _____

Fax: _____

PER MARYLAND STATE GUIDELINES, CHESAPEAKE PEDIATRICS HAS 21 BUSINESS DAYS TO RELEASE YOUR MEDICAL RECORDS

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: ENTIRE RECORDS LAST PHYSICAL & IMMUNIZATIONS IMMUNIZATION ONLY
LAB RESULTS OTHER SPECIFIED RECORDS: _____

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 Parent/Guardian (or Patient if 18 years or older)	Print Name of Parent/Guardian (or patient if 18 years or older)	Date	Relationship to Patient

Chesapeake Pediatric & Adolescent Associates P.A.

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29 Broad Street, Suite 201 Berlin, MD 21811

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