PEDIATRIC PARTNERS, LLC
4 C NORTH AVENUE SUITE 400
BEL AIR MARYLAND 21014

AUTHORIZATION FOR THE USE OF DISCLOSURE OF
PROTECTED HEALTH INFORMATION

INFORMATION TO BE RELEASED FROM:
Pediatric Partners, LLC
4 C North Avenue, Suite 400
Bel Air, MD 21014
Phone: 410-638-0239 Fax: 410-638-0282

I authorize Pediatric Partners, LLC to release medical records on:

_________________________________ ______________
(NAME) (DOB)

Mail Records to:
__________________________________ ( ) HAVE MY RECORDS AVAILABLE FOR PICK UP

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INFORMATION NEEDED:

_______ALL RECORDS _______ LABORATORY RESULTS
_______HOSPITALIZATIONS _______OPERATIVE REPORTS
_______IMMUNIZATIONS _______GROWTH CHART(S)

Reason for leaving the practice:
_____MOVING
_____INSURANCE
_____OTHER PLEASE EXPLAIN:
____
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I understand that I have the right to revoke this information in writing, at any time by sending such written notification to Pediatric Partners, LLC *Privacy Officer* 4 C North Avenue Suite 400, Bel Air MD 21014. I understand that a revocation is not effective to the extent that Pediatric Partners, LLC has relied on the use of disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may not longer be protected by federal or state law. Pediatric Partners, LLC will not base my treatment, payment, enrollment in a health plan or eligibility in a health plan for benefits on whether I provide authorization for the requested use of disclosure.

I understand that I have the right to: Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to extent the state law provides greater access rights) and to refuse to sign this authorization

____ _________________________
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE