

PEDIATRIC PARTNERS, LLC
8600 LASALLE AVENUE POTOMAC BUILDING # 105
BALTIMORE MD 21286

AUTHORIZATION FOR THE USE OF DISCLOSURE OF
PROTECTED HEALTH INFORMATION

INFORMATION TO BE RELEASED FROM:

Pediatric Partners, LLC
8600 LASALLE AVENUE POTOMAC BUILDING # 105
BALTIMORE MD 21286
Phone: 410-823-5232 Fax: 410-296-0257

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

(NAME) (DOB)

Mail Records to:

_____ () HAVE MY RECORDS AVAILABLE FOR PICK UP

INFORMATION NEEDED:

_____ ALL RECORDS _____ LABORATORY RESULTS
_____ HOSPITALIZATIONS _____ OPERATIVE REPORTS
_____ IMMUNIZATIONS _____ GROWTH CHART(S)

Reason for leaving the practice:

_____ MOVING
_____ INSURANCE
_____ OTHER PLEASE EXPLAIN:

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