BAY AREA PEDIATRICS

165 Log Canoe Circle
Suite E
Stevensville, Maryland 21666
Phone: 410-643-1000 Fax: 410-643-5200

PATIENT REQUEST FOR RECORDS

Authorization for Release of Protected Health Information (PHI)

Name of Patient: ______________________ **DOB:** ______________________

Address: ______________________ **Phone:** ______________________

____

I hereby request that ______________________ provide health records as follows:
(physician name)

1. Records to be Released *(check ALL that apply)*

Fax *(provide number)* ______________________

- ☐ History and Physical (most recent)
- ☐ Immunization Record
- ☐ Lab/Radiology Reports
- ☐ Progress Notes

2. Reason for Release

- ☐ Personal Copy
- ☐ Transfer to New Doctor
- ☐ Move
- ☐ Other *(specify)* ______________________

3. Select Delivery Method

- ☐ Pick up in person
- ☐ Fax *(provide fax number)* ______________________

4. Release PHI to

- ☐ Patient (same as above)
- ☐ Parent/Guardian ______________________ *(name)*
- ☐ Physician Practice/Other ______________________ *(name)*

______________________ *(street address)*

______________________ *(city, state, zip)*

Fees: I understand that I may incur a reasonable, cost-based fee where applicable for copying, postage, preparation and labor.

- ☐ I agree to pay all charges.
- ☐ Please contact me with estimated full cost before proceeding.

I have read and signed this authorization.

______________________ ______________________ ______________________
Signature *Date* *Relationship to Patient*