BRIGHT OAKS
Pediatric Center

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Bel Air, MD 21015
(p) 410-569-3300 (f) 410-569-8199
www.BrightOaksPediatrics.com

AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED MEDICAL INFORMATION

1. I authorize	**2. To release information to**
Name of Sending Person/Organization:	Name of Receiving Person/Organization: **Bright Oaks Pediatric Center**
Full Address: Phone: Fax:	Please Fax to 410-569-8199

3. Information to be released: (Check All Applicable)

- ☑ Immunization Record
- ☑ Most Recent Well Visit Note
- ☑ Growth Charts
- ☑ Lead Test Results
- ☑ Problem List
- ☑ Specialist Notes from the past year
- ☑ Newborn Screen
- ☐ If <2yrs: Birth Records

4. Purpose or need for disclosure:

- ☑ Continued Medical Care

By my signature below I acknowledge the following:

5. I understand that this authorization shall be valid for 1 year from the date of request below, unless otherwise indicated, and that I may revoke this consent in writing at any time except to the extent that the action has already been taken.
6. The requester may be provided with a copy of this authorization.
7. I understand that if my protected health information is disclosed to someone who is not required to comply with federal health insurance probability act and accountability act of 1996(HIPAA) regulations, then such information may be re-disclosed and would no longer be protected.
8. If this release pertains to alcohol, drug information, mental health problems, or psychotherapy, please note that this information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR, part 2). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient.
9. I understand that I have the right to inspect my child's protected health information and make authorization changes and copies, if needed.
10. I understand that a reasonable fee may be charged for duplication of records. The fee will include $0.76 per page for photocopying plus the actual cost of the postage and handling PLUS $22.88 for retrieval of records, if applicable.

Patient name _____ Date of Birth _____ Date of Request _____

Current Address _____ Daytime Phone Number _____

Signature _____ Printed Name of Authorized Parent/Guardian _____ Relationship to Patient _____