AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: _____________

I authorize the use or disclosure of the above named individual's health information as described below by the following organization:

BAY SHORE PEDIATRICS
130 HOSPITAL ROAD
SUITE 207
PRINCE FREDERICK, MD 20678
PHONE: 410-535-5959 FAX 410-535-0551

Reason for Request: ___Hours, ___ Location, ___Moving,
Other____

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

______ COMPLETE MEDICAL RECORDS
______ CONSULTATION REPORTS
______ IMMUNIZATION RECORDS

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. Unless otherwise revoked, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

This information may be disclosed to the following individual or organization:

____

Name (Practice or Physician) and Address

Please Note There Is A Fee For Medical Records (please check applicable boxes below):

$0.57 per page up to maximum fee of $80 per child for electronic copies provided in pdf format.
$0.73 per page for photocopies

Patient/Parent/Guardian's signature: ___________________________________ Date: _______

If signed by Legal Representative, Relationship to Patient ________________________________

This faxed information is intended only for the use of the individual or entity to which it is addressed and contains information that is confidential. Furthermore, this information may be protected by federal law relating to confidentiality (42 cfr part 2) prohibiting any further disclosure. if the reader of this message is not the intended recipient or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any review, dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify Bay Shore Pediatrics immediately at the below listed above. Thank you!