



## Pediatric Providers

4000 Old Court Road, Suite 205, Pikesville, MD 21208

Phone: 410-484-9950 Fax: 410-484-9953 Email: admin@pediatricproviders.com

### PERMISSION TO SHARE HEALTH INFORMATION

This form authorizes Pediatric Providers to request your child's health information from another provider. Completing all sections ensures records are routed correctly. This form complies with HIPAA and Maryland state law.

#### SECTION 1 — PATIENT INFORMATION

|                          |                      |
|--------------------------|----------------------|
| <b>Patient Full Name</b> | <b>Date of Birth</b> |
|--------------------------|----------------------|

#### SECTION 2 — REQUESTING PROVIDER (Records being requested BY this office)

*This section identifies the office requesting the records. It is pre-filled for your convenience — please verify accuracy.*

|                                                                        |                                                                                                    |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| <b>Name of Practice</b><br>Pediatric Providers                         | <b>Provider Name (if applicable)</b>                                                               |
| <b>Address</b><br>4000 Old Court Road, Suite 205, Pikesville, MD 21208 | <b>Phone / Fax / Email</b><br>Phone: 410-484-9950 Fax: 410-484-9953   admin@pediatricproviders.com |

#### SECTION 3 — SENDING PROVIDER (Records to be sent FROM this provider/facility)

*Please complete all contact information for the provider or facility that holds the records we are requesting.*

|                                    |                                      |
|------------------------------------|--------------------------------------|
| <b>Name of Practice / Facility</b> | <b>Provider Name (if applicable)</b> |
| <b>Address</b>                     | <b>City / State / Zip</b>            |
| <b>Phone</b>                       | <b>Fax</b>                           |

#### SECTION 4 — REASON FOR REQUEST (Check all that apply)

|                                                          |                                                         |                                                                 |
|----------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> New Patient — Establishing Care | <input type="checkbox"/> Referral to Specialist         | <input type="checkbox"/> Continuity of Care / Ongoing Treatment |
| <input type="checkbox"/> Prior Records / History Review  | <input type="checkbox"/> School / Daycare Requirement   | <input type="checkbox"/> Legal / Court Order                    |
| <input type="checkbox"/> Personal / Patient Copy         | <input type="checkbox"/> Hospital / Emergency Follow-Up | <input type="checkbox"/> Other: _____                           |

#### SECTION 5 — RECORDS REQUESTED (Check all that apply)

|                                                                   |                                               |                                                  |
|-------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Full Medical Record                      | <input type="checkbox"/> Visit / Office Notes | <input type="checkbox"/> Lab / Test Results      |
| <input type="checkbox"/> Immunization Records                     | <input type="checkbox"/> Referral Records     | <input type="checkbox"/> X-Ray / Imaging Reports |
| <input type="checkbox"/> Other: _____                             |                                               |                                                  |
| <b>Date Range of Records (if applicable): From _____ To _____</b> |                                               |                                                  |

#### SECTION 6 — EXTRA-PROTECTED INFORMATION (Maryland Law — authorize only what applies)

*Maryland law provides special protection for the following types of information. Check ONLY the boxes you wish to authorize. Unchecked items will NOT be released.*

|                                               |                                                |                                                      |
|-----------------------------------------------|------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> HIV/AIDS Information | <input type="checkbox"/> Mental Health Records | <input type="checkbox"/> Drug / Alcohol Records      |
| <input type="checkbox"/> Reproductive Health  | <input type="checkbox"/> Genetic Information   | <input type="checkbox"/> Other Sensitive Information |

#### SECTION 7 — EXPIRATION OF THIS AUTHORIZATION

|                                                    |                                               |                                             |
|----------------------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> One year from date signed | <input type="checkbox"/> Specific date: _____ | <input type="checkbox"/> After event: _____ |
|----------------------------------------------------|-----------------------------------------------|---------------------------------------------|

#### SECTION 8 — YOUR RIGHTS

- You may revoke this authorization at any time in writing, unless the records have already been sent.
- Once information is released, it may be re-disclosed by the recipient and may no longer be protected by HIPAA.
- Your child's care at Pediatric Providers will NOT be affected if you choose not to sign this form.

#### SECTION 9 — SIGNATURE

|                                              |                             |                                |
|----------------------------------------------|-----------------------------|--------------------------------|
| <b>Signature of Parent or Legal Guardian</b> | <b>Date</b>                 | <b>Relationship to Patient</b> |
| <b>Print Name</b>                            | <b>Contact Phone Number</b> |                                |

*For Office Use Only — Date Received: \_\_\_\_\_ Processed By: \_\_\_\_\_ Date Sent/Faxed: \_\_\_\_\_*