AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

For this authorization, "My Health Information" is;

_____Complete Record

_____Immunizations

_____Specific Notes _____

_____Labs

_____Limited Records (Growth Chart, Immunizations, Lead Results and Last Physical)

For the date starting _____ through _____

I hereby authorize _____ to disclose my health information to:

Peds In A Pod Pediatrics
1105 North Point Blvd
Suite 306
Baltimore MD 21224
Phone: 410-285-5437
Fax: 410-285-7333

Reason for Release: ___ Transferring Primary Care

_____Specialty Appointment

_____ Other (specify) _____

I understand that this authorization gives my parent/legal guardian permission to release any Protected Health Information (PHI) that is contained in the Medical Records including information and records or copies of records relating to the history, diagnosis, treatments or services rendered to me in connection with any condition or disease. This includes information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any

I release Peds In A Pod Pediatrics, LLC and the Recipent/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Peds In a Pod Pediatrics, LLC, provided that I do so in writing and to the extent that you have disclosed the information in reliance on this authorization.

This authorization will automatically expire on _____

Patient Name: _____

Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relation to patient: _____