STAR CHOICE PEDIATRICS

6785 Business Parkway Suite 101 Elkridge, MD 21075 Tel: 240-247-2422 fax: 240-247-2440

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

☐ Mail to Medical Office ***(** we will charge a mail fee))*** ☐ Mail to My Address ***(** we will charge a mail fee)***

☐ Fax to New Provider ***(we will fax only necessary PHI)*** ☐ Will Pick Up Records at Star Choice Pediatrics

I authorize Star Choice Pediatrics to release my (or my children's) Medical Records to the following person/organization:

Name of Person/ Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

DOCUMENTS REQUESTED:

☐ **Entire Chart** (check one) ○ **Paper copy** (fee for Paper copy **.76 cents for each page**- call for an estimate cost)

○ **Electronic Copy (e-fax) (Available only for transferring patient record to another medical office)**

☐ **Basic Record Overview** (No Charge): Immunization Record, Growth Chart, last Physical, Recent Lab(s)

☐ **Other Document Request :** _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Reason for Request

○ Transfer to another provider – Provider Name: _____Phone#_____
Reason: _____

○ Legal Issues ○ Personal use ○ Insurance purposes ○ Other _____

I understand that medical records to be released may contain information related to HIV status, AIDS, sexually transmitted disease, alcohol or drug use, mental health services, or any other information entered into my chart, and I hereby authorize release of this information. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has been taken.

Patient/Parent/Legal Guardian Name: _____ **Phone#:** _____

Address: _____

_____ _____

Signature of Patient/Parent/Legal Guardian **Date**

SCPeds Staff Initials/Date Completed: _____