MEDICAL RECORD RELEASE FORM

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

☐ **Mail to Patient Address on File**

☐ **Fax to Medical Office/Pediatrician (*Need Fax #)**

I authorize Star Choice Pediatrics LLC to release the protected health information of: **(Use one form per patient)**

Patient Name:_____ **Date of Birth:**_____ **Address:**

_____ **Phone:** _____

_____

Documents Released:

*** Entire Chart** (Includes patient visit notes, diagnostic tests, immunization records,surveys/screenings etc. completed at Star Choice Pediatrics LLC Medical Office Only)

The Protected Health Information (PHI) is to be released to: **(Must be Patient if 18 years of age or older or Legal Parent/ Legal Guardian or Medical Office/New Provider) (All items must be completed in full or the request will not be honored. Fax # required if sending to Medical Office/New Provider)**

Name/Medical Office:_____

Address:_____

Phone #: _____ **Fax #:** _____

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 already been taken per request.

Please return completed Medical Release Form to the following:

Star Choice Pediatrics LLC Medical Records Department
starchoicepediatricsMD@gmail.com
Fax: (240) 247-2440

Please visit www.starchoicepediatrics.com for Custodian of Record information and updates on how to access your medical records.

_____ _____

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

SCPeds Staff Initials/Date Completed:_____